

SCHEDULE 1 – GLOSSRY OF TERMS

<p>ABUSE</p>	<p>Abuse is any action that harms another person or infringes their human rights. This can include:-</p> <ul style="list-style-type: none"> • Physical abuse such as hitting, burning, pushing or kicking someone. • Verbal abuse such as shouting or swearing • Emotional abuse such as bullying, taunting, threatening or humiliating someone. • Sexual abuse such as inappropriate touching or forcing someone to take part in or witness any sexual act against their will. • Financial abuse such as misusing, keeping or taking someone’s money, property or other belongings without their agreement. • Neglect such as not providing necessary food, heating, care or medicine. <p>Discrimination such as ill-treatment or harassment based on a person’s age, sex, sexuality, disability, religious beliefs or ethnic group.</p>
<p>ACCREDITATION</p>	<p>Adults & Communities Directorate’s registration and accreditation scheme to register and accredit services, goods and activities featured in the Catalogue. The scheme ultimately seeks to promote safe services as citizens exercise their right to choose services.</p>
<p>ADR NOTICE</p>	<p>Alternative Dispute Resolution A notice issued under Clause 31 which covers problem solving options outside of formal court proceedings.</p>
<p>ADULTS & COMMUNITIES LOCAL OFFICE</p>	<p>The Adults & Communities Directorate office where the Service User’s Social Worker/Care Manager is located.</p>
<p>ADVOCACY</p>	<p>Advocacy is the process of independently acting on behalf of, or representing the interests of, another person, or group, to secure the rights or services to which they are entitled and “Advocate” shall be construed accordingly. In terms of this contract, an advocate may also refer to a carer, family or friends of the Service User.</p>
<p>AGREEMENT OR FRAMEWORK AGREEMENT</p>	<p>This Framework Agreement. A framework is an agreement with a provider or providers to establish terms governing contracts that may be awarded during the life of the agreement. In other words, it is a general term for agreements that set out terms and conditions for making specific purchases (call offs).</p>
<p>ALLOCATED WORKER</p>	<p>The Care Worker assigned to assist the Service User.</p>
<p>ASSESSMENT AND REASSESSMENT</p>	<p>An assessment by the Council under Section 47 of the National Health Service and Community Care Act 1990. This is undertaken when it appears to the Council that a person may be in need of services. Where it so appears, then the Council shall carry out or arrange to have carried out the assessment of that person's needs and, having regard to the results of that assessment, shall decide whether the assessed</p>

	need calls for the provision by them of any such services.
AUTHORISATION OF AN EXTERNAL PLACEMENT FORM (formerly SS833)	Completed by the Council for confirmation and finance details of an accommodation based placement. This details of service delivery cost and is signed off by the budget holder. The provider receives a copy for their records.
AUTHORISED OFFICER	The officer authorised by the Council to formally let and supervise this Contract as notified to the Provider from time to time. The Authorised Officer has nominated representatives within the Council's Adults & Communities Directorate who are authorised to liaise with the Provider on a regular basis. The Council may, by notice in writing to the Provider, change the delegation of the Authorised Officer.
BEST VALUE DUTY	The duty imposed on the Council by Section 3 of the Local Government Act 1999 in relation to the Service.
BROKERAGE	Brokerage is the means to support Service Users to: <ul style="list-style-type: none"> • plan relevant support to meet needs / deliver outcomes • identify and arrange delivery of appropriate support or services • arrange ongoing management of support or services
CARE HOME WITH NURSING	These homes provide the same help and assistance with personal care as those without nursing care but they also have professional registered nurses and experienced care assistants in constant attendance that can provide 24-hour nursing care services for more complex health needs. These homes are for people who have been assessed as requiring a health care professional (nurse) delivering elements of care.
CARE HOME WITHOUT NURSING	These homes are where people live either short or long term. The homes provide help and assistance with personal care, continence management, food and diet and simple treatments
CARE QUALITY COMMISSION (CQC)	CQC is the independent regulator of health and social care services in England. They register and inspect care providers under the Care Standards Act 2000. Their responsibilities include the registration of all health and social care agencies carrying out regulated activities for example personal care. The main administration centre of the Care Quality Commission is at Citygate, Gallowgate, Newcastle Upon Tyne, NE1 4PA Telephone 03000 616161.
CARE PLAN	A plan or "Individual Service Statement", drawn up by the Provider describing how day to day services will be delivered to meet the objectives of the Service User's Support Plan.
CARE WORKER	Those staff who deliver the Service on behalf of the Provider in the Service User's own home or within a placement setting.
CEDR	The Centre for Effective Dispute Resolution, International Dispute Resolution Centre, 70 Fleet Street, London EC4Y 1EU.

CHANGE OF CIRCUMSTANCES FORM (formerly SS854)	Completed by the Provider to notify the Council of any events or change in circumstances relating to the Service User. For example, hospitalisation or where the Service User is absent for any reason.
CHOICE DIRECTIVE	The Choice of Accommodation Direction 1992 under which Service Users have the right to choose how their care is provided, who provides their care care and where their care is delivered.
CONSTITUENCY	Birmingham City Council constituencies are the parliamentary constituencies that took effect prior to the last general election. Each constituency is then divided into wards. The Constituencies are: <ul style="list-style-type: none"> • Edgbaston • Erdington • Hall Green • Hodge Hill • Ladywood • Northfield • Perry Barr • Selly Oak • Sutton Coldfield • Yardley
CONTRACT AWARD LETTER	A letter sent by the Council to the Provider notifying the Provider of the award of the Agreement from a specified date.
CONTRACT MANAGEMENT	The approach structures a range of activities that are carried out simultaneously to keep the arrangements between the citizen, the supplier and BCC running smoothly. Commissioning's approach to Contract Management will: <ul style="list-style-type: none"> • Work with Providers to deliver quantifiable improvements in outcomes for citizens. • Drive improvement in the performance of Providers across market sectors • Seek to de-risking the delivery of social care by all Providers • Strive to ensure that the taxpayer is funding services that deliver best possible value for money • Operate as an effective agent (within an overall Supplier Relationship Management model) to maintain and shape Birmingham City Council's social care market.
CONTRACT MANAGEMENT MEETING	This term is used to describe a conversation between the Authorised Officer and the Provider. This may take the form of a face to face meeting, telephone call, visit, email or letter.
CONTRACT PERIOD	The duration and dates of the Agreement as defined in clause 4.
THE COUNCIL	Birmingham City Council which will normally be represented in relation to the Agreement by staff employed within the Adults and Communities Directorate of the Council.
DEPRIVATION OF LIBERTY (DoLS)	The Mental Capacity Act Deprivation of Liberty safeguards were introduced into the Mental Capacity

	<p>Act 2005 through the Mental Health Act 2007. The MCA DOL safeguards apply to anyone:-</p> <ul style="list-style-type: none"> • aged 18 and over • who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability • who lacks the capacity to give informed consent to the arrangements made for their care and / or treatment and • for whom Deprivation of Liberty (within the meaning of Article 5 of the ECHR) is considered after an independent assessment to be necessary in their best interests to protect them from harm. <p>The respective safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements</p>
DIRECT PAYMENT	A cash payment paid directly to the Service User so they can purchase their own services directly e.g. rather than having them purchased and/or managed by the Council.
END OF LIFE CARE	End-of-life care refers to medical care not only of patients in the final hours or days of their lives, but more broadly, medical care of all those with a terminal illness or terminal condition that has become advanced, progressive and incurable.
EMPLOYEE	For the purposes of this Framework Agreement, Employees shall include volunteers, temporary placements, agents and subcontractors where the contract permits.
FORCE MAJEURE	Means any of the following events: acts of God, including fire, flood, earthquake, wind, storm or other adverse weather conditions, natural disaster, or effects of pandemic illness, war, threat of or preparation for war, armed conflict, acts of terrorism, imposition of sanctions, and similar events diplomatic relations or similar actions, but excluding unplanned industrial action.
FUTURE OPERATING MODEL (FOM)	<p>The FOM outlines the key components (strategic, managerial and operational) required from the Council in order to respond to the predicted challenges. The FOM depicts how the Council will function in the future; and is based upon a 10 year model.</p> <p>The FOM for adult commissioning seeks to move away from the Council having a direct contractual relationship with providers and moving towards contracts being established solely between providers and Service Users ('Personal Contracts'), where this is practical, within Legislation and where the Service User has capacity to make that choice. The Council will interact with providers via a partnership approach known as Supplier Relationship Management (SRM).</p>

HOME SUPPORT	The provision of a service in the Service Users own home in accordance with Schedule 2.. Also referred to as home care, domiciliary care or home help. It is when care workers visit people in their own homes to give them help and support with activities of daily living. Care workers can help with personal care needs, such as washing and getting dressed and practical tasks such as preparing simple snacks or frozen meals.
INAPPROPRIATE PLACEMENT	A placement in a Care Home that does not meet the assessed needs of the Service User, whether such assessment is a Birmingham City Council Assessment or a Registered Nursing Assessment, and “a placement has become inappropriate” shall be construed accordingly.
INDIVIDUAL AGREEMENT	An Individual Service Order or Individual Placement Agreement.
INDIVIDUAL PLACEMENT AGREEMENT	An individual placement agreement (for Care Homes with or without Nursing) between the Council, the Provider and the Service User setting out the terms on which the Service will be provided to the Service User.
INDIVIDUAL BUDGET	A sum of money allocated to the Service User, to meet their assessed needs, but is made up of social care funding only.
INDIVIDUAL SERVICE ORDER	An individual service order (for Home Care) between the Council, the Provider and the Service User setting out the terms on which the Service will be provided to the Service User.
INTERIM CARE	A temporary service provided to people being discharged from an NHS bedded unit, while they wait for their longer term services to be agreed and arranged.
LEGISLATION	Any Act of Parliament or subordinate legislation within the meaning of Section 21 (1) of the Interpretation Act 1978, any exercise of the Royal Prerogative, and any enforceable community right within the meaning of Section 2 of the European Communities Act 1972, in each case in the United Kingdom.
MARKETPLACE	The Marketplace set up by Adults & Communities Directorate to support and enable citizens to make informed decisions when selecting their support options. The Catalogue will be an online, interactive directory of goods, services and activities which citizens can choose to meet their outcomes. Providers on the Catalogue will undergo a registration and/or accreditation process to ensure they meet minimum requirements.
MODEL PROCEDURE	CEDR’s Model Mediation Procedure and Contract.
MENTAL CAPACITY ACT PRINCIPLES	The Mental Capacity Act 2005 is underpinned by five key principles (Section 1, MCA):

	<p>Principle 1: A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.</p> <p>Principle 2: Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.</p> <p>Principle 3: Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.</p> <p>Principle 4: Best interests – anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.</p> <p>Principle 5: Less restrictive option – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person’s rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.</p>
<p>MENTAL CAPACITY</p>	<p>Having mental capacity means that a person is able to make their own decisions. You should always start from the assumption that the person has the capacity to make the decision in question (principle 1). You should also be able to show that you have made every effort to encourage and support the person to make the decision themselves (principle 2). You must also remember that if a person makes a decision which you consider eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3). Under the MCA, you are required to make an assessment of capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be. You might need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition.</p>

	Assessments of capacity should be time and decision specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone.
NEW ENTRANT TRAINEE	<p>A person that is leaving an educational establishment (e.g. school college or university) or a training provider; or:</p> <ul style="list-style-type: none"> • an adult who has not been employed in the care industry during the previous six months and who is seeking employment that includes training towards a qualification agreed by the Council; or • a trainee employed by another Care contractor or supplier to the Council whose contract of employment is being terminated and who is therefore seeking another position to complete their training period.
NHS CLUSTER	A bringing together of the boards and management structures of groups of PCTs to identify and implement management cost reductions and improve the quality and productivity of local health services. The member PCTs remain legally responsible and accountable for the performance and commissioning of services for their own populations until formally replaced by GP led Clinical Commissioning Groups .
NORMAL WORKING HOURS	08:45 to 17:15 Monday to Thursday and 08:45 to 16:15 on Friday (Bank Holidays excluded) or otherwise as notified by the Council to the Provider.
OUTCOMES	Outcomes can be defined as “the impacts or end results of services on a person’s life”. Providing services to meet outcomes rather than to complete the tasks decided by the social worker, gives the Service User much better choice and control about what their care Provider does for them.
OUTREACH	Those staff who deliver the Service on behalf of the Provider in the Service User’s own home.
PALLIATIVE CARE	Palliative care is a specialised area of healthcare that focuses on relieving and preventing the suffering of patients. Unlike hospice care, palliative medicine is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses and those living with chronic diseases, as well as patients who are nearing the end of life.
PRN MEDICINES	As and when required medicines, as described in Schedules 13 and 14
PROVIDER	The organisation, service provider or person providing the Service for the benefit of the Service User in accordance with the terms of this Agreement.
REGISTRATION	Registration under the Health and Social Care Act 2008 to the regulating body the Care Quality Commission. This is a legal requirement for all Providers who provide health and adult social care services in England. “Registered” shall be construed

	accordingly.
RESIDENTIAL CARE	The provision of the Service in a Care Home (with or without nursing) in accordance with Schedule 3..
RESOURCE ALLOCATION SYSTEM (RAS)	The RAS is a system which calculates sum of money against the Service User's eligible needs. The more eligible needs a Service User has, the more money will be awarded to the Service User to meet their needs. The amount of money is known as the indicative Individual Budget and becomes the agreed Individual Budget once it has been agreed that the Service User's needs can be met within the allocated amount and in some cases taking into consideration market prices for services.
SAFEGUARDING	Action to detect, prevent and respond to actual and potential abuse or to protect persons thought to be at risk of abuse whether physical, sexual or psychological or neglect or poor standards of care by any other person or persons that violate their human and/or civil rights.
SCHEDULES	The Schedules to this Agreement.
SERVICE	The Service that the Provider is to provide to the Service User in accordance with the Individual Agreement or Third Party Contract this Agreement and its Service Specifications.
SERVICE SPECIFICATION	The document which outlines the requirements for the Service including principles, outcomes and service description.
SERVICE USER	A person who has been assessed by the Council as being in need of a Service according to the criteria at the time of assessment and agreed by the Council. This term also extends to carers or other representatives of the individual receiving the Service, where the context permits, in particular a court appointed depute or holder of a lasting power of attorney for the person.
SHORT BREAK	
SOCIAL WORKER/CARE MANAGER	The Council's Adults & Communities Directorate representative who has carried out the assessment of social care needs.
SUBCONTRACTOR	A subcontractor is an individual or in many cases a business that is appointed under a contract by the Provider, to perform part or all of the Provider's obligations under this Agreement.
SUBSTITUTED SERVICE	As defined in Clause 22 of the Framework.
SUPPORT PACKAGE	The plan and the Service put in place to meet a Service User's eligible needs.
SUPPORT PLAN	The plan drawn up by the Council's Adults & Communities Directorate or the Service User's Health Worker in conjunction with the Service User and his/her carer(s), following an assessment of need and calculation of the Service User's Individual Budget. The plan details the Service and actions required to meet the Service User's needs and outcomes.

SUPPORT PLAN REVIEW	A review of the Support Plan in accordance with clause 17 of this Agreement, normally undertaken by a Social Worker, to ensure the Service User's needs is being met. The review can also be attended by the Provider, Service User, Health Authority representative and the Service User's carer or Advocate.
SUPPLIER RELATIONSHIP MANAGEMENT	Building partnerships to meet citizen needs as efficiently and effectively as possible
TEMPORARY PLACEMENT	The placement of a Service User up to six months and "Temporarily Placed" shall be construed accordingly.
THIRD PARTY CONTRACT	A contract for the provision of the Service by the Provider directly between the Provider and the Service User either using their Individual Budget or the Service User's own finances.
THIRD PARTY TOP UP	The arrangement whereby a person other than the Service User agrees to pay a regular sum of money above the Service User's Individual Budget. The payment is to facilitate the purchase of the Service from a Provider to allow the Service User to exercise choice of Service Provision.
THREE WAY AGREEMENT (formerly SS841)	The three way agreement concerns the placement of a Service User in a Care Home and details who will pay the third party contribution.
TRIAL PERIOD	The first 28 days of any placement made through this Agreement.
VARIATION FORM (formerly SS8046)	The Variation Form is to be completed by either the Council or the Provider, to notify a change of a community based service provision (Home Support). The variation is to the usual service ordered on the Individual Service Order.
VULNERABLE ADULT	Birmingham Safeguarding Adults Board (BSAB) defines a vulnerable adult as being a person -: <ul style="list-style-type: none"> • Who is or may be in need of community care services because of frailty, learning or physical or sensory or mental health issues • Who is or may be unable to take care of him or herself, or take steps to protect him or herself from significant harm or exploitation
WORKING DAYS	This does not include weekends or Bank Holidays in England

SCHEDULE 2 - SERVICE SPECIFICATION FOR HOME SUPPORT SERVICES

1. Introduction

- 1.1. This schedule sets out the Specification relating to the provision of Home Support for the Council. It describes the key features of the service to be purchased and should also be read in conjunction with the Framework Agreement terms and conditions and the Support Plan and Individual Service Order..
- 1.2. The Council and local Health partners will expect the Service to provide:
 - 1.2.1. A personalised and responsive service
 - 1.2.2. Enabling care and support
 - 1.2.3. Stimulation
 - 1.2.4. activities that are meaningful for Service Users
- 1.3. The aim of Home Support is to support Service Users who, because of frailty, illness and/or disability are unable to sustain a desired and 'normal' life without assistance. This will be achieved by enabling the Service User to acquire, reacquire and maintain their own skills in line with their agreed outcomes so that they are able to remain in their own home and achieve and maintain their potential in relation to physical, intellectual, emotional and social capacity.

2. Service Outcomes

- 2.1. The Service outcomes are:
 - 2.1.1. Enhancing quality of life for people with care and support needs
 - 2.1.2. Delaying and reducing the need for care and support
 - 2.1.3. Ensuring that people have a positive experience of care and support
 - 2.1.4. Safeguarding adults whose circumstances make them vulnerable and protecting them from harm.
- 2.2. This Specification demonstrates the commitment of the Council to work in partnership with Providers to ensure a robust focus on service delivery that achieve optimum outcomes for the Service User, in line with the four quality statements (domains) in the new Adult Social Care Outcomes Framework.

3. Service Standards

- 3.1. The Provider will:
 - 3.1.1. Ensure an individual Service Plan is in place and that this forms the meeting of the terms and conditions of this Agreement
 - 3.1.2. Promote Service User involvement and engagement in service delivery by supporting Service Users to assist in writing/designing their support plan
 - 3.1.3. Deliver person led care; Service Users goals, targets and objectives should remain the focus of care at all times
 - 3.1.4. Home Support shall be available to /service Users 365 days per year.

- 3.1.5. The majority of services purchased will be between the hours of 7am and 11pm throughout the week, however, on occasions services will need to be provided outside of these hours.
- 3.1.6. Acknowledge that all care workers are visitors in a Service User's home and should act accordingly.
- 3.1.7. Acknowledge and respect people's gender, sexual orientation, age, ability, race, religion, culture and lifestyle.
- 3.1.8. Maximise Service User's self-care abilities and independence by helping and encouraging people to do for themselves rather than having tasks done for them.
- 3.1.9. Maximise Service User's satisfaction with the service provided
- 3.1.10. Recognise people's individuality and personal preferences for example by not adhering rigidly to prescribed timescales or tasks
- 3.1.11. Provide support for carers, whether relatives or friends, and recognise the views of other family members.
- 3.1.12. Support Service Users to experience safe and appropriate care that meets their needs and protects their rights
- 3.1.13. Provide protection to people who need it, including safeguarding everyone.
- 3.1.14. Work in partnership with the Service User and their carers to ensure that expectations and wishes have the best chance of being met and the Service Users
- 3.1.15. Strive for continuity of care by limiting the number of domiciliary care workers assigned to an individual Service User
- 3.1.16. Deliver services that offer choice and flexibility with skilled and competent staff
- 3.1.17. To help Service Users to be confident to complain about services without fear of consequences and ensure issues raised are addressed within the prescribed procedure
- 3.1.18. 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
- 3.1.19. Treat people as individuals and promote each person's dignity, privacy and independence in line with a person-centred care approach

4. Service Description

4.1. The tasks and support to be undertaken with and for Service Users are listed below. This list is neither exhaustive nor needed in all cases, and will depend on which tasks are identified as most likely to meet agreed Service User outcomes. It is also important to emphasise that the list below is not prescriptive and should not preclude imaginative and alternative solutions which may better suit a Service User.

4.2 The precise details of the tasks to be completed will need to be negotiated and agreed between the Service User, relatives, carers, advocates and the Provider in order to achieve

the outcomes stated in the Service User's Support Plan. The details of these tasks must be clearly recorded in a personal Service User plan and linked to the identified outcomes

4.3 The main Components of General Home Care are:

Personal Care; Practical Support with Household Management

4.3.1 Personal Care

These care tasks shall generally mean assistance to Service Users (falling short of nursing care) which if not performed would result in a significant risk of deterioration in the Service User's quality of life.

Personal Care includes assistance with:

Transfers from or to bed/chair/toilet;

Assisting Service Users getting up and putting to bed;

Personal washing, bathing/showering and maintaining good personal hygiene toileting, shaving (use of cut throat razors prohibited), washing and trimming of hair, hand and finger nail care, foot care, not toe nail care (which requires a state registered chiropodist);

Eating and drinking;

Assisting Service Users with the administration of medicines;

Assisting Service Users in dealing with correspondence and handling their money;

Changing of catheter bags;

Escorting to access community provision (e.g. shops, health appointments, leisure pursuits);

Services to give carers a break (e.g. sitting services)

Encouraging the continuation of hobbies and social activities.

This list is not exhaustive and is intended to be illustrative only.

4.3.2 Practical Support with Household Management

Practical domestic support refers to a variety of tasks concerned with the basic household management and with maintaining a safe and hygienic environment.

The following list is not exhaustive and is intended to be illustrative only.

Cleaning and House Care

Cleaning the home, which may include vacuuming, sweeping, washing-up, polishing, cleaning floors and internal windows, bathrooms, kitchens, toilets etc. using appropriate domestic equipment and appliances as available in the Service User's home;

Tidying the home;

Making the beds and changing bed linen;

Lighting fires, boilers etc.

Disposing of household and personal rubbish;

Assist with feeding and managing of pets subject to risk assessment;

Assisting with the consequences of household emergencies.

Shopping and Meal Preparation

Reasonable shopping;

Assisting with, or preparing, food and drink.

Laundry Services

As part of a personal or domestic care package to include:

Laundering clothes and household linen (including fouled linen) using either the Service User's own equipment or a launderette, and ironing.

Other Household Management

Collection of benefits, prescriptions – in accordance with appropriate procedures;

Payment of bills – in accordance with appropriate procedures;

Maintain awareness of the safety of the home environment, alerting the appropriate person where risk is identified.

5. Service Flexibility

- 5.1. Agreed service provision details will need to be recorded in the personal Service User plan. It should however be noted that Providers need to be flexible in the provision of services, including tasks, hours and timing of visits. This is in accordance with the Core Principles under the Service Standards.
- 5.2. The Council will need to confirm whether the agreed tasks are in accordance with the agreed outcomes.
- 5.3. In the event that provision of care or support occasionally falls short of or exceeds the maximum agreed hours per week, the Provider and Service User may agree to log any surplus or deficit. Providers will thus need to ensure that they have recording systems to manage these eventualities.

5.4. Whilst flexibility in service provision is paramount, Providers and their staff must only provide services which are legal and meet the Service Users stated outcomes. In addition, in delivering a person centred service, service requests should not be judged against an individual Provider or worker's own moral or ethical standards.

SCHEDULE 3 – SERVICE SPECIFICATION FOR CARE HOMES WITH AND WITHOUT NURSING SERVICES

1. Introduction

1.1. This schedule sets out the Service Specification relating to the provision of Care Homes with and without nursing for the Council. It describes the key features of the service to be purchased and should also be read in conjunction with the Framework Agreement terms and conditions and the applicable Individual Agreement and Support Plan.

1.2. The Council and local Health colleagues will expect the service to provide:

- 1.2.1. a personalised and responsive service;
- 1.2.2. enabling care and support;
- 1.2.3. stimulation;
- 1.2.4. activities that are meaningful for Service Users.

1.3. This will be achieved by enabling the Service User to acquire, reacquire and maintain their own skills in line with their agreed outcomes so that they are able to achieve and maintain their potential in relation to physical, intellectual, emotional and social capacity. The Service will be personalised and enable the Service User to live as an individual, treated with dignity and respect.

2. Service Outcomes

2.1. The Service outcomes are:

- 2.1.1. Enhancing quality of life for people with care and support needs.
- 2.1.2. Delaying and reducing the need for care and support.
- 2.1.3. Ensuring that people have a positive experience of care and support.
- 2.1.4. Safeguarding adults whose circumstances make them vulnerable and protecting them from harm.

2.2. This Specification demonstrates the commitment of the Council to work in partnership with Providers to ensure a robust focus on service delivery that achieve optimum outcomes for the Service User, in line with the four quality statements (domains) in the new Adult Social Care Outcomes Framework.

3. Service Standards

3.1. The Provider will:

- 3.1.1. Have a brochure/guide in appropriate formats as to the service provided, is available for Service Users (or potential Service Users) of the Service, Carers and professionals involved in setting up a Service.
- 3.1.2. Meet the Service User's needs as detailed within their support/care plan. This may include supporting all aspects of personal care needs and to work in conjunction with multi agency care programme approach.
- 3.1.3. Will be able to demonstrate that every Individual has had a fully documented assessment on admission or has access to NHS Community Services and the continuing use of recognised clinical assessment tools. The list is not exhaustive and should be added to according to need but is to include:

- 3.1.3.1. Tissue Viability Assessment

- 3.1.3.2. Nutritional Assessment
 - 3.1.3.3. Mobility Assessment
 - 3.1.3.4. Communication Assessment
 - 3.1.3.5. Continence Assessment
 - 3.1.3.6. Mental, emotional and psychological requirements portrayal
 - 3.1.3.7. Personal and oral hygiene assessment
- 3.1.4. With reference to the Support Plan, produce a detailed plan of how they will meet assessed needs. This will include details of ongoing reviews.
 - 3.1.5. Where appropriate, contribute to an agreed programme of rehabilitation designed to assist Service Users to re-establish lost skills, maintain current skills, or develop new skills in personal care; this may include enabling Service Users to assist with tasks around the home.
 - 3.1.6. Provide social and occupational activities which enhance the quality of life of Service Users;
 - 3.1.7. Have mechanisms for Service User engagement in the running of the home. For example, resident meetings, involvement in the recruitment of staff.
 - 3.1.8. Protect the Service User's legal rights, and that they have access to an advocate or other representatives if required.
 - 3.1.9. Increase support to a Service User in periods of temporary variations or fluctuations in their lifestyle or circumstances.
 - 3.1.10. Have a proactive approach to the changing needs of Service Users due to deterioration in physical or mental health, challenging or forensic behaviour. The Provider, where possible, should be flexible enough to meet such need without the Service User having to lose their Service.
 - 3.1.11. Promote services to the Service User this will encourage and maintain healthy living. For example, a healthy diet.
 - 3.1.12. Have access, aids and adaptations to cope with an impairment or disability and ensure safe usage in accordance with appropriate guidelines. Please refer to schedule 15 – Equipment for further guidance.
 - 3.1.13. Support Service Users to access appropriate benefits, financial advice and assistance with personal budgeting. For example, debt advice or payment of bills.
 - 3.1.14. Where appropriate, devise an exit strategy in conjunction with the statutory services. This may include resettlement activities and 'move-on' advice.
 - 3.1.15. Where appropriate, support Service Users to take part in recreational activities. For example, holidays.
 - 3.1.16. Adopt a preventative model focus.
 - 3.1.17. Help Service Users to be confident enough to comment on services without fear of consequences and ensure issues raised are addressed within the prescribed procedure(s).
 - 3.1.18. Encourage networks for carers, whether relatives or friends, and recognise the views of other family members.

- 3.1.19. Support Service Users to access interpreters as agreed in the Council's Support Plan.
- 3.1.20. Ensure and evidence the Service User's satisfaction with the service provided.
- 3.1.21. Deliver person led care: Service User goals, targets and objectives should remain the focus of care at all times.
- 3.1.22. Acknowledge and respect people's gender, sexual orientation, age, ability, race, religion, culture and lifestyle.
- 3.1.23. Maximise Service Users' self-care abilities and independence by helping and encouraging people to do for themselves rather than having tasks done for them.
- 3.1.24. Maximise Service User satisfaction with the service provided.
- 3.1.25. Have policies on the action to take if Service Users bring forbidden substances into the placement to give or sell to others.
- 3.1.26. Recognise people's individuality and personal preferences for example by not adhering rigidly to prescribed timescales or tasks.
- 3.1.27. Provide support for carers, whether relatives or friends, and recognise the views of other family members.
- 3.1.28. Support Service Users to experience safe and appropriate care that meets their needs and protects their rights
- 3.1.29. Work in partnership with the Service User and their carers to ensure that expectations and wishes have the best chance of being met.
- 3.1.30. To deliver services that offer choice and flexibility with skilled and competent staff.
- 3.1.31. Maintain Service User dignity: The Provider will recognise 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 Standard Framework/ Liverpool Care Pathway.
- 3.1.32. Treat people as individuals and promote each person's dignity, privacy and independence in line with a person-centred care approach.

SCHEDULE 4 – SERVICE SPECIFICATION FOR REHABILITATION IN SUBSTANCE MISUSE SERVICE

This section details further service standards which are specific to particular Service Users receiving services for Substance Misuse.

The below standards should be followed in conjunction with the generic service standards in schedule 3.

Rehabilitation in Substance misuse - Therapeutic programmes
<u>Service standards</u>
The Provider Must ensure that: <ol style="list-style-type: none">1. Units should have policies on the action to take if Service Users bring forbidden substances into the placement to give or sell to others.2. Drug and alcohol rehabilitation services are structured time limited therapeutic programmes aimed at enabling Service Users to regain and develop maximum independence in a therapeutic environment in order to return to independent living in their own home in the community.3. The Council will Purchase therapeutic programmes that enable individuals who are dependent on drugs and / or alcohol to work towards long term abstinence and recovery. They can be delivered in residential care homes. This specification will address the Purchaser of rehabilitation programmes in a Care Home or Care Home with Nursing.4. Restrictions will be applied for therapeutic reasons to the formation of exclusive relationships between Service Users whilst undergoing substance misuse rehabilitation.

Rehabilitation in Substance misuse - Rehabilitation programmes
<u>Service standards</u>
The Provider Must ensure that: <ol style="list-style-type: none">5. All rehabilitation programmes address:<ul style="list-style-type: none">• Education and awareness of the effects of problem substance misuse on the body• Relapse prevention• Alternatives to substance misuse• Self management of daily living skills such as personal hygiene, daily routines & time management, domestic skills including budgeting, shopping, cooking and housework, managing free time.• Relationships with others including rebuilding family relationships• Personal skills, self esteem, assertiveness skill• Criminality• Training, education and employment needs• Harm minimisation• Continuity of Care• Community Reintegration• House meetings to address residents issues as and when they arise6. The Council will also purchase rehabilitation programmes that are able to

address parenting skills, other addictive behaviours, rough sleeping, dual diagnosis (of mental health problems), and cultural needs. This would include programmes that would lead to vocational qualifications.

7. Substance misuse rehabilitation placements are always of a time-limited nature and permanent placements cannot be considered.

Rehabilitation in Substance misuse - Service Delivery

Service standards

The Provider Must ensure that:

8. Prospective Service Users will be made aware of the type, range and standards of services available from a placement prior to their admission, including the restrictions in place to enable and address therapeutic needs. Whilst service users retain the right to leave a particular placement, they will be supported to stay and enabled to recognise that having difficulties in with elements of a programme is part of the process of relapse prevention and moving towards abstinent recovery.
9. Service Users are required prior to admission, to give their consent to the conditions and requirements of the regime that they select to undergo and thereby they agree to the restrictions imposed on their freedoms for therapeutic reasons.
10. The major input of 'personal care' is enabling, counselling and / or group-work rather than physical care.
11. The therapeutic plan of the provision is to provide service users with a structured day that they will be made aware of and agreed on admission. Placements should make the approach explicit in their brochures. The provider will determine the timetable. As the programme progresses there will be some phased withdrawal of controls to plan and enable community re-integration. The nature and content of the treatment plan will also provide education on and make explicit that continuing /aftercare following placement is an integral part of the individual plan.
12. Service Users have to agree to restrictions being put on contacts with their social networks such as visits, telephone contact and correspondence with people outside the Unit including family members, to enable them to engage in the structured programme- and to gain maximum benefit from the placement alongside reducing risk and minimise the likelihood of relapse.
13. The Council will not purchase programmes of detoxification in the Service Users own home, nursing home or hospital. Such treatment is the responsibility of the National Health Service.
14. An overall programme of activities will be presented in a timetable form, covering at least 8 hours a day and 6 days a week. Activities will be itemised stating when they will occur and who will be responsible for their implementation. This timetable **will** include all activities that are part of the therapeutic programme including information sessions, counselling, group work, private time on assignments, free time and recreational periods that are designed to promote and build social skills, self esteem and assertiveness.
15. It is expected that Service Users can expect a minimum of four hours of counselling a day, five days a week. This counselling will be provided in individual or group-work sessions.
16. Where Service Users have responsibilities towards dependent others particularly children, the maintenance and development of relationships must be considered in the individual treatment plan and timetable of the placement, in accordance with visiting times and therapeutic programme. Service users

need to be made aware at assessment and in the providers brochures that contact will be subject to the requirements of the regime they select to undergo. In circumstance where this is not appropriate the Care Manager will notify the Provider.

Rehabilitation in Substance misuse - Treatment Plan

Service standards

The Provider Must ensure that:

17. A written agreement between the Service Users or their representative and the Provider must be in place alongside the Treatment Plan that covers issues such as:
 - Service Users rights.
 - Any limits to the denial of choices, privacy and human rights where this is essential for therapeutic reasons to change destructive behaviour patterns.
 - Unacceptable conduct and the circumstances under which a service Users would be asked to leave.
 - Smoking policy.
 - Formation of exclusive relationships within the provider unit.
 - Insurance of personal items.
 - Charges and how bills will be rendered and to whom.
 - Visitors and domestic arrangements.
 - Complaints procedures.
 - Handling of abuse between Service Users and between Service Users and staff.
18. Each Service User will have a copy of their Treatment Plan and a written agreement covering the conditions of the placement.

Rehabilitation in Substance misuse - Discharge

Service standards

The Provider Must ensure that:

19. Providers, the placing agency and the Service Users act in partnership to ensure that discharge care arrangements exist that are relevant to the needs of the service Users and are workable. Respective responsibilities of all involved are to be clear whether the discharge is planned or unplanned.
20. ***the provider allocates a Key Worker who will be the link between the Service User in the residential unit and the Care Coordinator in the community***
21. Service Users will not be in touch with these placement units on a long term or permanent basis, so it is crucial that the issue of leaving is addressed from the outset.
22. Discharge arrangements are the responsibility of The Council's Care Coordinator and there must be a clear agreement with the Service Users on where they will go on leaving their placement.
23. Discharge must ideally be a planned event and a system must be in place for informing the Service Users' ***Care Coordinator*** of the outcome of their placement including any potential breakdown or problems arising.

24. The Provider must send a Discharge Report to the **Care Coordinator** within 7 working days of discharge. This will include a progress report and what travel arrangements have been made.
25. The conditions under which an emergency discharge is required must be made clear in writing on admission.
26. Where there is an emergency discharge, the following arrangements will apply:
 - The **Care Coordinator** will be informed within one working day.
 - The Service Users' family will be informed if they have any current involvement.
 - There must be an agreed form of transport back to the area of origin and arranged by the Provider.
 - There must be written statements of the conditions under which a Service Users may return to the treatment unit.

Rehabilitation in Substance misuse - Medication / Detoxification, Therapy and Specialist Support

Service standards

The Provider Must ensure that:

27. A clear distinction is made between detoxification and any other medication programme. The management of Service Users medication is undertaken in a responsible and sensitive way allowing for self-medication where appropriate.
28. If there is a programme of detoxification treatment undertaken on site that requires medical or nursing support on a 24-hour basis, this should be provided in accordance with the Registered Homes Act 1984 Part ii.
29. Any medication programme in place must be overseen by a qualified and experienced medical practitioner with active nursing support as required under the Care Standard Act 2008.
30. Where a Service Users registers with a GP or dentist, the nature of the placement should be made known to the health practitioner to avoid opportunities for procurement of forbidden substances.
31. The assessment of risk to themselves and to others, of allowing a Service Users to retain and administer their own medication, should be done on admission and notified to the Care Manager. It should be recorded and regularly reviewed.
32. Where a Service Users requires treatment of a specialist nature that can not be provided by the staff at the Unit, the Provider must liaise with the Care Manager and must arrange for these services to be provided locally.
33. Staff and volunteers, who have themselves had drug and/or alcohol dependency problems, must be able to demonstrate at least 2 years sobriety and stability in recovery. This does not apply where Service Users who have progressed through the programme and are used as Mentors for people newly engaged in the programme.
34. No more than 50% of staff will be comprised of people recovering from drug or alcohol dependency.
35. When specific treatment work is being undertaken such as individual or group counselling, there shall be two Counsellors on the premises, one of whom can be someone in training.

Rehabilitation in Substance misuse - Additional requirements for residential units

Service standards

The Provider Must ensure that:

36. Overnight arrangements must include a minimum of one member of staff on the premises and another member of staff to be available for emergencies. These arrangements apply equally to times including weekends when no specific counselling work is being undertaken. Residents must have access to a trained counsellor 24 hours a day via an on call system.

Rehabilitation in Substance misuse - Privacy

Service standards

The Provider Must ensure that:

37. All homes should have a policy on confidentiality and rights to privacy. However, the nature of substance misuse rehabilitation requires units to be free to search for evidence of compliance with the conditions of the placement especially substance misuse.
38. Limits may also need to be imposed on those who can be invited to the Unit and to a Service User's room and the length of time that a Service User can spend alone in their room.
39. It will not generally be appropriate to provide Service Users with lockable bedrooms or storage facilities until a risk assessment indicates otherwise.
40. A clearly designated and private area will be available for privacy during visits from family and the Care Manager.
41. Service Users should only be offered single rooms when they have been assessed as able to comply with the Provider's conditions on substance use. Room sharing will therefore be acceptable especially in the early stages of a placement but only on a single gender basis. It must be clear to residents, the circumstances under which they can choose to be accommodated in a single room.

SCHEDULE 5 – SERVICE SPECIFICATION FOR SERVICE USERS WITH CHALLENGING NEEDS INCLUDING DELIRIUM AND DEMENTIA

1. A number of users of health and social care support, whether bed based or community based, will have challenging needs as a result of Behavioural and Psychological Symptoms of their illness or disability, often referred to as ‘Challenging Behaviour’.
2. Typically this will be a result of functional or organic brain disorders such as a Mental Health problem, a Learning Disability, Dementia, an Acquired Brain Injury, or as a result of Substance Misuse.
3. The challenging presentation may be short term or long term, and is often accompanied by a lack of capacity in relation to some or all aspects of care and accommodation.
4. In all such cases the principles of the Mental Capacity Act should be applied and followed.
5. Where there is a sudden change in behaviour or cognition, the potential for a delirium should be recognised and a health assessment sought.

6. MANAGEMENT OF DELIRIUM

Delirium is a state of mental confusion that can occur if a person becomes medically unwell. Causes of delirium include medical problems such as pain, constipation and infection, surgery, medications, malnourishment and dehydration.

NB: Do not assume that all delirium or fever is due to urinary tract infections as this can lead staff to fail to look for other possible causes. Give facts and observations only when referring to medical staff.

It often starts suddenly and usually lifts when the underlying condition gets better. It can be frightening – not only for the person who is unwell, but also for those around them. See the Royal College of Psychiatrists’ guidance for more information:

<http://www.rcpsych.ac.uk/mentalhealthinfo/problems/physicalillness/delirium.aspx>

If someone has delirium then the physical causes need to be treated so a GP should be called straight away. Sedative medications can make the delirium worse.

People with delirium should be helped to feel calmer and more in control and staff should:

- Stay calm and reassure.
- Talk in short, simple sentences.
- Check that they have been understood. Repeat things if necessary.
- Try not to agree with any unusual or incorrect ideas, but tactfully disagree or change the subject.
- Remind the person of what is happening and how they are doing.
- Remind them of the time and date.
- Make sure they can see a clock or a calendar.
- Try to make sure that someone they know well is with them. This is most important during the evening, when confusion often gets worse.

- Prompt people to use their glasses and hearing aid.
- Help them to eat and drink.
- Have a light on at night so they can see where they are if they wake up.

7. MANAGEMENT OF DEMENTIA

Listed below are the 4 main types of dementia but there are other much rarer types. It can be helpful to know which type of dementia a person has, as it is a good predictor of the main types of problems and needs they will have.

- Alzheimer's dementia is caused when nerves in the brain disintegrate, known as tangles and small clumps of protein, known as plaques, develop around brain cells. This disrupts the normal workings of the brain. Is the cause of about 50% dementia.
- Vascular dementia is caused by problems with blood circulation and results in parts of the brain not receiving enough blood and oxygen. It can be caused by damaged or blocked blood vessels or a series of small strokes. Is the cause of about 10% of dementia.
- Dementia with Lewy bodies is caused when abnormal structures, known as Lewy bodies, develop inside the brain. People with Parkinson's also have Lewy bodies in their brain. Is the cause of about 20% of dementia.
- Fronto-temporal dementia is caused when the front two parts of the brain begin to shrink. Unlike other types of dementia, fronto-temporal dementia usually develops in people who are under 65. It is much rarer than other types of dementia.
- Other forms include HIV, alcohol related, Picks and CJD

Unfortunately, people with dementia may develop more than one form of dementia, most commonly a mixture of Alzheimer's and Vascular dementias.

OUTLOOK FOR THE PERSON

Generally dementia is a gradual process with no cure and symptoms that will get worse over time resulting in death. However, there are a number of effective treatments including anti dementia drugs that can help people cope better with their symptoms and improve their quality of life. Medical input should be sought for any sudden deterioration in an individual as it is potentially caused by, or an indicator of another medical condition.

While people are still able to make important decisions, they should be advised of the importance of having an up to date will and setting up Lasting Powers of Attorney for welfare and financial matters as they cannot be done after mental capacity is lost. Care homes must be seen to remain neutral in these matters by offering to obtain independent external assistance.

Similarly residents should be given early opportunities to record their wishes regarding health treatments especially for their End of Life Care.

The onset of symptoms and the speed of decline can be delayed by ensuring residents have effective control of their blood pressure, take exercise and engage in stimulating activities.

GOOD MANAGEMENT: THE CARE BUNDLE:

Training in dementia care and the provision of a positive social and physical environment is vital. Much of the stress experienced by residents with dementia is due to a lack of understanding of their needs and can result in agitation and challenging behaviours.

Good practice guidance developed by Professor Dawn Brooker from Worcester University for use in acute general hospitals is likely to be useful to care homes. As part of person centred care, Professor Brooker recommends particular attention to 3 key elements, known as the Care Bundle, for the care of people with cognitive impairments. It is easy for staff to remember these 3 elements of care and by integrating them into their practice, many of the problems encountered by staff will be prevented and the resident will experience an improved quality of life.

The Care Bundle approach is good practice in both dementia and delirium care.

Effective communication:

- Use of 'All About Me' individual communication guides for staff prepared with the individual and / or relatives that list meaningful topics of conversation, preferred ways of having things done especially preferred food, drink and personal care and preferred ways of being approached [e.g. see www.communicationpassports.org]
- Use of appropriate complexity of language based on the person's level of understanding and short term memory. If a person's level of understanding is unclear refer for assessment from Speech and language Therapy via the GP.
- Creation of a sense of reassurance and safety
- Quick response to calls for assistance
- Proactive contact by staff if assistance has not been requested within an hour
- Knowledge where possible of the historical meaning of behaviours with agreed responses
- Staff who accept that short term memory may have gone and calmly remind people where they are or are going
- Staff who know who to report to if they cannot ameliorate a problem or have noted signs of something problematic
- Access to a full range of therapies and aids for orientation and recall.
- Spotting non verbal signs of distress to pick up possible pain, fever, constipation and other symptoms that could be alleviated. The Disability Distress Assessment Tool (DISDAT) is useful for this.
- Giving of facts and observations about symptoms rather than attempted diagnoses when referring to healthcare professionals.
- Awareness that a sudden deterioration in speech and understanding may indicate an acute medical condition and will require assessment by GP or Rapid Response service or 999 if an emergency.

NB: Do not assume that all confusion or fever is due to urinary tract infections as this can lead staff to fail to look for other possible causes.

Adequate nutrition and hydration

As dementia progresses, people may become unaware of hunger or thirst and become less able to manage food or drink. Many problems of agitation result from being undernourished or dehydrated.

- People's weight should be recorded on entry to the home and monitored for change. If there is concern about weight or weight change staff should offer an agreed minimum level of calories and liquids each day and record the daily intake. A senior member of staff should regularly check these recordings for trends and report concerns to the GP

- On admission, care home staff should ensure they are aware of any allergies or sensitivities.
- Care plans should contain details of favourite and culturally appropriate foods and drinks
- Staff should be aware that swallowing difficulties and choking may increase as dementia progresses and that a referral to Speech and Language Therapy via the GP or SPA (Single Point of Access) may be helpful. Indicators of swallowing difficulties can be: holding food in the mouth; excessive coughing when eating or drinking, drooling, episodes of choking, inappropriate pace of eating.
- Use of a nutritional screening tool (e.g. MUST) to assess if a person is at risk of being malnourished. Refer to a dietician (via the GP or SPA) if this indicates concerns.
- The care setting should implement a protected meal time where all care staff are able to assist residents with nutritional needs. People may need increased time to eat.
- Sometimes eating in social groups in dining areas encourages greater intake of food and drinks
- Sometimes visitors are better able to encourage greater intake of food and drinks
- Conduct assessments of non verbal signs of dehydration and malnutrition including monitoring of bowel movements for signs of constipation
- Offer finger foods and small portions and liquids several times a day
- Pay attention to dental health as this is a significantly under diagnosed problem for people with communication difficulties and can be a source of pain and attendant challenging behaviour. Ensure the person has their dentures for meals.

Appropriate / simply designed physical environment

The Department of Health website contains detailed information on the design of environments.

Produced to reduce problems in health care premises, it can easily be adapted for care homes

- Ensure environments are quiet and uncluttered and easy to navigate without assistance. Use landmark objects to aid way finding
- Toilet doors should be marked or coloured to be easily spotted and be easy to reach
- Cleaning cupboard and utility room doors where residents are denied access for safety reasons should be imaginatively concealed such as painted the same colour as walls
- Maximise daylight by keeping windows clean and use of daylight bulbs etc to reduce visual impairment and enhance mood
- Prompt the use of spectacles and hearing aids if prescribed or contact GP for sight or hearing checks if sight or hearing loss is suspected
- Place washable familiar objects from a person's past within their eye line
- Arrange objects such as clothing in sequence to make tasks easier to complete unaided
- Provide safe and circular areas for walking including enclosed gardens
- Prompt the use of walking aids where prescribed to reduce falls

PATHWAY FOR DIAGNOSIS OF MEMORY IMPAIRMENT AND / OR DEMENTIA:

Care homes should ensure on admission that an appropriate assessment of cognitive abilities such as memory and thinking has been completed and the results recorded. It should be re-done at least annually. This assessment should pay attention to any challenging behaviours

Where an assessment has not been carried out, simple free self assessment tests aimed at people concerned about early memory problems can be downloaded from the internet for use as part of the ongoing assessment of residents:

- 'Test Your Memory' is available in a UK version that can be downloaded from the Internet through the Alzheimer's Reading Room. A score of 42 or less out of 50 would indicate concern that should be followed up by a GP
- Montreal Cognitive Assessment Test (MOCA) is a 10 minute cognitive screening tool available in several languages on the internet. www.mocatest.org

It should be remembered that people may perform badly on these tests if they have suddenly become confused or delirious but for them cognitive impairment is likely to be short-lived. A diagnosis of dementia should always be pursued for older people with memory problems that have lasted more than 6 months. Any concerns should be reported to the GP who will decide whether to refer to the local Memory Assessment Service or Community Mental Health Team in the Birmingham and Solihull Mental Health Foundation Trust.

Although it may be initially distressing, there is good evidence that people's levels of anxiety are reduced by being given a diagnosis of dementia as it explains problems they have been experiencing. Care home staff will need to know the services available for people to talk through the meaning of their diagnosis and to help them plan for the future.

People who receive a diagnosis of dementia may be prescribed anti dementia drugs and will be reviewed on a regular basis. These drugs will be stopped when they are no longer of benefit and particularly as someone comes close to the end of their life.

Knowledge of the type of dementia diagnosed will be helpful to staff in understanding current behaviours and for predicting what the future may bring for an individual resident.

Dementia, delirium and depression can all present in similar ways particularly agitation or passivity and therefore can be difficult to diagnose. The following table summarises the key features.

Features		Dementia	Depression
Onset	Sudden	Gradual	Can coincide with life changes
Course	Fluctuates	Progressive	Variable
Duration	Days-Weeks	Months-Years	Months-Years
Memory	Impaired and Sudden	Impaired	Patchy and variable
Consciousness	Altered	Clear	Clear
Thinking	Disorganised incoherent	Few complete thoughts. Word finding problems	Normal but thoughts of hopelessness
Attention	Impaired	Normal (unless severe)	Minimal impairment but easily distracted
Sleep	Nocturnal confusion	Often disturbed, nocturnal wandering	Early wakening

Guidance is given here on the things to look out for, ways of preventing them occurring and recommended ways of managing them. It has been put together by leading clinical specialists from the Birmingham and Solihull Cluster and informed by national best practice.

8. MANAGEMENT OF CHALLENGING BEHAVIOURS:

It must be recognised that 'challenging behaviour' is in itself a form of communication within the context of impaired or lost communication skills. In the main the 'management' of challenging behaviour should be through a person centred approach that recognises this as an attempt to communicate need or distress as they way needs are being met or unmet, and seeks to understand and respond appropriately to the communication rather than seeking to 'manage' the behaviour. Non the less there will be some people for whom the behaviour presents a continuing risk to themselves and others and who will need specialist provision and input to appropriately meet their support needs, in such circumstances:

- A multi-disciplinary assessment of need should be sought to ensure the care / support remains current and appropriate to meet all the identified needs.

- The multi-disciplinary assessment should include relevant mental health professional input.
- Due to Behavioural and Psychological Symptoms the level of staff time and assistance required to appropriately meet the person's support needs safely will be high.
- The person in receipt of direct care will require assistance from staff who have a specialist knowledge base and skills in working with people who have challenging needs. This will include being able to recognise and respond appropriately to individuals whose communication skills are impaired to the extent that they may communicate their needs, or dissatisfaction with how those needs are met, through behaviour that may be seen as challenging or disruptive.
- Whilst some people may fluctuate, or have unpredictable levels of need, the multi disciplinary assessment will have shown that the specialist challenging support needs are present most days requiring specialist input to reduce, or minimise, episodes, and the level of, behaviours that challenge so as to maintain manageable levels of risk.

For those people whose needs are appropriately met within a specialist challenging needs provision so that their support needs may appear to no longer meet the criteria, then a multi disciplinary assessment and review of need must take place to determine if the level of support needs to stay in place to maintain well-being and avoid an escalation in support needs.

Challenging behaviours often result from not being able to communicate frustrations or discomfort. They may be distressing for the individual concerned as well as difficult for those around them including staff. Behaviours can take the form of persistent calling out, agitation, self harm, harm to others or harm to property.

It is not acceptable for staff to use any form of restraint, verbal abuse or isolation to control / punish challenging behaviour. Staff must be trained in techniques for preventing the triggers for behaviours and non-physical and psychosocial methods for handling them.

Challenging behaviour is best prevented before it becomes distressing. An assessment of the main triggers and causes should be completed and an agreed plan for prevention and management of incidents communicated to all staff. The plan should be reviewed regularly and updated if necessary to ensure it is effective.

Awareness of a person's individual personality, preferences, interests and ways of occupying themselves are an excellent start. A supportive, empathic and active social environment in the home will prevent many of the difficulties associated with cognitive impairment becoming challenging behaviours.

An initial attempt to see situations where the behaviours are occurring through the persons own eyes should be made in an attempt to understand the meaning or purpose. With this it should be possible to develop care or management plans that seek to meet or respond to the person's needs in more appropriate ways or that enable people to express themselves without the need to be challenging.

Where staff need to intervene especially if there are safety issues, they must be clear on the care home policy for what staff can and cannot do. Incidents should be followed by a review of the prevention and management plan.

In the case where distress is significant, persistent or there is a risk of harm to the person or others a referral to mental health services should be made via the GP. Staff should collect information about incidents that includes details of the frequency of incidents, events that lead up to them, how each incident was managed and the results.

Sedative including anti psychotic medication will only be used as a last resort and should be frequently reviewed.

9 ADDITIONAL CARE REQUIREMENTS UNDER CONTINUING NHS HEALTH CARE

The range of specialist care to be provided:

- Supervision, intervention and advice from a Registered Nurse on a daily basis.
- Effective management of behavioural and cognitive deficits and the effects using non physical interventions wherever possible.
- Registered Nurses and Care Staff who are trained in the specific management of individuals who are elderly, frail and Mentally Ill.

Enhanced observations or supervision:

If the resident requires enhanced observation as part of the delivery of care services, the responsible commissioner is to be notified within 24hrs. If additional funding is agreed it will be evaluated on a weekly basis whilst actions are taken to resolve the issues.

SCHEDULE 6 – ALLOCATION OF WORK TO PROVIDERS

1. Individual Agreements under the Framework Agreement will advertised via a mini competition process to relevant categories of providers; based upon the service user's requirements; and then awarded to a provider/s based upon a quality and price assessment.
2. The mini-competition process will facilitate short-listing and selection of a provider. The selection process will build in Service User choice in line with the Choice Directive.
3. To implement a clear and transparent process both for the Provider and for the Council to operate, at the point where providers are applying to be on the Framework Agreement, they have to meet a selection criteria; and will then be categorised based upon CQC service types and specialisms.
4. A Service Provider will be selected to deliver a care package in line with the following process:
 - a. A list of potential providers from the framework, who can meet the needs of the service user, will be generated. This will be based upon: provider categories, geographic location and any specific specialist and/or cultural requirements.
 - b. Notification of the care package would be sent out to this list of providers by email with the service user's requirements. Providers will be asked to respond i.e. bid within a defined period of time stating:
 - i. How they will meet the needs and outcomes of the service user.
 - ii. What price they will charge.
5. Bids will be evaluated from the providers who have responded, any unsuitable bids will be discounted. The bids will be scored on the basis of quality and price criteria.
6. A shortlist of the top-three providers based upon combined quality and price scores will be created.
7. Service users will have the choice out of which of the three shortlisted providers will deliver their care package. Alternatively, where the Service User and/or advocate cannot and does not want to choose, the Council will select the provider who was ranked no 1 in the shortlist to deliver the care package. Where the Service User exercises choice and wants to choose an alternative provider, if there is a price difference the Service User will pay the difference via a Third Party contribution.
8. The Council is in the process of implementing a micro-procurement system that will automate key components of the mini-competition process. This system will not alter the fundamental components of the work allocation process.

SCHEDULE 7 -FINANCE, INVOICING AND PAYMENTS

1. INTRODUCTION

- 1.1. The Council will only make payments where it has been agreed that a Service needs to be provided in respect of a Service User and that the services to be provided can be provided are within the scope of the Framework Agreement
- 1.2. The amount payable by the Council and (if applicable) any third party funder to the Provider in respect of the Service User's accommodation and care in the Care Home shall not include any payment for nursing care. The NHS Cluster shall pay to the Service Provider Funded Nursing Care (FNC) for that Service User.
- 1.3. For the avoidance of doubt the Provider shall not increase the fees payable by the Council as a result of FNC being paid or becoming payable by the NHS Cluster.

2. CONFIRMATION OF CARE REQUIREMENTS

- 2.1. The confirmation of the care requirements will be through the issuing of a form identifying the Service required. The specific form issued is dependent on the type of Service being put in place and will be as detailed below depending on the nature of the Service:
 - a. SS8045 – Individual Service Order for Home Care (Home Support Services)
 - b. SS833– Community Care Authorisation of External Placement (Care homes with and without Nursing)
- 2.2. No payment will be made without the issue of either of the above forms (as applicable).
- 2.3. The forms detailed in paragraph 2.1 above confirming the Service required shall specify the amount of money available to the Service User to spend on the Service. The Individual Agreement shall include details of the Service to be provided, which has been agreed with the Service User, and a copy of the Support Plan.
- 2.4. Where the needs of the Service User change, then the Provider shall contact the Council to agree a reassessment. Any subsequent variation to the Service provided to the Service User will be reflected within the Service User's Individual Budget. If a health need is identified, the Council will make an appropriate referral for review.
- 2.5. Where a variation to the Service provided is required, the Provider will confirm the changes through the submission of :
 - a. SS8046 – Variation form for Home Support package. This is intended to reflect a short term variation in care. Where a permanent change in care needs is required, a new Individual Service Order for Home Care form will be issued. Further clarification is set out in paragraph 5 of this Schedule.
 - b. SS854 – Notice of Events or Change of Circumstances for Care Homes with and Without Nursing.
- 2.6. Payments for the Service provided will not be varied without the issue of either of the above forms (as applicable).

- 2.7. Where a permanent change to the Service provided is required, this will only be agreed following a Support Plan Review and the issue of new Individual Agreements and Support Plan forms.

3. PAYMENT FOR SERVICES PROVIDED

- 3.1. Payment for the Service delivered is made on the basis of four-week periods, which will be notified to the Provider prior to the start of each financial year.
- 3.2. The Council uses two separate methods for generating payments:
- a. Care Homes with and without Nursing provision will be paid via schedule payments, where payment is generated by the information held in the Council's client database. In these circumstances, the Provider is not required to submit an invoice for payment; and
 - b. Home Support Service provision will be paid on the basis of an invoice submitted by the Provider.
- 3.3. If the Provider is to be paid on the basis of schedule payments, it will be notified in advance and will not be required to submit an invoice on a four weekly basis for the Service delivered.
- 3.4. If the Provider is not notified pursuant to paragraph 3.3 above it shall submit an invoice covering each four-week period on the invoice due date in order to generate payment. The invoice due date will be notified to the Provider prior to the start of the financial year.
- 3.5. When the Provider is notified that it will be paid on a schedule basis:
- a. The Provider must notify the Council immediately of any payment made for any part of the Service which has not been provided.
 - b. Where an overpayment is identified it will be deducted from the next payment due for the Service.
 - c. Where an overpayment is identified and there are no further payments due to the Provider, an invoice will be issued by the Council to the Provider which will be due for immediate payment.
- 3.6. If the Provider is required to submit an invoice for the Service provided it shall:
- a. Submit an invoice on the specified invoice date providing the required information detailed below;
 - b. Only claim for the Service which has been provided during each payment period;
 - c. Ensure that evidence of the delivery of the Service is obtained prior to the creation of any invoice and that such evidence is retained in the Provider's place of business;
 - d. Ensure that any part of the Service not delivered is confirmed to the Council on the variation to service form SS8046. Forms are to be submitted electronically via the Provider's portal account.
 - e. Ensure that the evidence of the Service which has been provided is available for inspection by the Council at any time; and

- f. Ensure that its invoices comply with any information governance requirements notified by the Council to the Provider from time to time.

3.7. Where the required evidence supporting the delivery of the Service is not provided, the Council:

- a. Will not be liable for the payment claimed for the provision of such Service;
- b. Will reclaim the due amount where payment has already been made;
- c. May deem the Provider to be in breach of contract.

4. SUBMISSION OF INVOICES

4.1. Where the Provider is providing a Service for which it is required to submit invoices, it shall submit its invoices to:
PO Box 13969,
Birmingham,
B2 2GD.

4.2. The Council shall make such payment as is due to the Provider within 28 days of the receipt of an invoice provided that the invoice:

- a. Includes all the details required by the Council under this Agreement; and
- b. Is accurate.

4.3. If an invoice is incorrect or does not include details required by the Council, it will be returned to the Provider accompanied by the Invoice Summary sheet on which will be detailed the reason for the return of any invoice. In this event, the 28 day period shall not apply, but the Council shall make any payment which becomes due as soon as is practicable.

4.4. Where there has been an overpayment to the Provider (e.g. as a result of an unauthorised variation of the Service, or otherwise) the Council shall be entitled to recover the amount of such overpayment and the equivalent sum will be withheld from subsequent due payments or recovered as a simple debt.

4.5. The making of any payment by the Council to the Provider shall not constitute a waiver of any claim that the Council may have that the Provider has failed to provide the Service or any part of it or otherwise breached the Agreement.

5. VARIATION OF A HOME SUPPORT PACKAGE

5.1. A Variation Form is intended for use as a method of notification of essential information between the Provider and the Council. It cannot be used for any long-term amendment to an Individual Service Order except for the termination of a service.

5.2. Any significant and/or enduring change in circumstances of a Service User must be notified by the Provider to the Council for re-assessment and confirmed in writing using the Variation Form.

- 5.3. The Variation Form should be completed electronically and sent to the Council via the Provider's portal account.
- 5.4. Where the Provider considers that the Service User in respect of whom an Individual Service Order has been issued requires an additional Service:-
- a. Where an emergency situation is discovered when the Provider's Care Worker arrives for an already placed order, that situation should be dealt with and the Council will pay for the additional hours of Service for that one episode. The Provider should notify the Social Worker as identified on the Individual Service Order within the time prescribed in clause 16.7 of the Framework Agreement and confirmed in writing using the Variation Form.
 - b. If the emergency is outside of normal office hours then authorisation can be obtained from the **Emergency Duty Team** on 0121 675 4806.
 - c. In all other cases where the Provider believes that additional Service is required the Social Worker should be informed and, if it is agreed, will issue a new revised Individual Service Order.
- 5.5. Where the procedure set out in this clause 5 is not followed the Council shall not be liable for payment for any change in the provided Service. The Service User shall not be required or requested by the Provider to make any contributions towards the cost of any additional Service.

6. PAYMENTS FOLLOWING ADMISSION TO HOSPITAL (Care Homes with and without Nursing)

6.1. This section (6) shall not apply to Home Support Services

- 6.2. Payment to the Provider will be reduced to 80% of the weekly rate from the day after admission to hospital, for a period of up to 42 days.
- 6.3. In the event that the Service User's hospitalisation extends beyond 42 days all payments will cease unless otherwise agreed by the Council and the NHS Cluster in writing wherein the above clause (6.2) will continue to apply. Such agreement will follow a Support Plan Review that will take place no later than the 35th day of absence due to hospitalisation or other nursing accommodation outside of the Care Home..
- 6.4. Following 14 days' absence of the Service User for any reason other than hospitalisation, payment of the fees payable to the Provider for the Service provided to the Service User shall cease unless otherwise agreed by the Council in writing.
- 6.5. The Provider shall not, without the Council's prior written consent, sub-let or allow any other occupation of the Service User's room during periods of temporary absence up to 42 days.
- 6.6. The Provider shall maintain accurate and up to date records relating to all temporary absences of Service Users and shall permit the Council and NHS Cluster, on 24 hours notice, to inspect and take copies of such records at the Care Home.
- 6.7. The Service Provider's invoices shall take account of the provisions of this clause.

7. FOLLOWING THE DEATH OF A SERVICE USER (Care Homes with and without Nursing)

7.1. This Section (7) shall not apply to Home Support Services.

7.2. Following the death of a Service User, the Provider shall notify the Council in accordance with clause 16.7 and the NHS Cluster within 24 hours of such notification.

7.3. The Council payment will cease two days following the date of death, payable at the weekly pro rata rate.

SCHEDULE 8 – NON TAKE UP OF THE SERVICE, ABSENCE OF THE SERVICE USER, NOTICE PERIODS AND TERMINATION AND RELATED PAYMENTS

1. NON TAKE UP OF A SUPPORT PACKAGE

- 1.1 When Services have been arranged and set up via an Individual Agreement by the Council on behalf of a Service User, but the Service is subsequently not taken up by the Service User, the provisions of this paragraph 1 of Schedule 8 will apply.
- 1.2 In relation to Care Homes with and without Nursing, where the Service is cancelled within a short period of commencement by the Council, the Provider will be paid its reasonable costs incurred in starting up the Service (provided they are evidenced) plus the fee for any actual provision of the Service. As a maximum, the Provider will be paid:-
 - 1.2.1 Less than seven days take up of Service – three days (or equivalent) Payment
 - 1.2.2 Seven days or more – one week's payment
 - 1.2.3 Any third party contribution due to the Provider must still be paid by the third party and the Council shall not be liable for any such third party contributions.
- 1.3 For the avoidance of doubt this paragraph 1 shall not apply to Home Support.

2. ABSENCE OF THE SERVICE USER (HOME SUPPORT SERVICES)

- 2.1 Any absences of the Service User shall be notified by the Provider to the Council in accordance with Clause 16.6 of the Agreement. Where notice of planned absences is not given as required under Clause 16.6, the Council shall pay for the planned Service for the first day of absence only.
- 2.2 Where the Service User does not require the Service due to any planned absence for holidays or respite care, the Council or the Service User shall give a minimum of 2 Working Days' notice to the Provider which notice shall be confirmed by the submission of a Variation Form (SS8046) and the Provider shall suspend the Service for the time specified. The Provider, Service User or their carer should contact the Service User's Social Worker to ensure they are aware of every planned absence.
- 2.3 In the case of unplanned absences due to hospitalisation or the death of the Service User, the Service User(if applicable), their carer or the Social Worker should make every effort to inform the Provider that the Service is not required. However, where notice has not been given then the Council shall pay the Provider for the first and only planned service episode of the unplanned absence.

3. ABSENCE OF THE SERVICE USER (CARE HOMES WITH AND WITHOUT NURSING)

- 3.1 Any absences of the Service User shall be notified by the Provider to the relevant Council social work team in accordance with Clause 16.6 (Terms and Conditions) and Section 6 of Schedule 7 (Finance, Invoicing and Payments) shall apply to payments to the Provider during any period of absence.

4. TERMINATION OF THE INDIVIDUAL SERVICE ORDER (HOME SUPPORT)

4.1 The Council may give a minimum of two working days' notice of termination of an Individual Service Order, wherever possible with the agreement of the Service User. -

4.1.1 However, in certain cases, e.g. the Provider's breach of contract, unsatisfactory Service provisions or a serious complaint against the Provider, the Council shall give the Provider a minimum of 6 hours' notice of the termination of an Individual Service Order. This may be by telephone call in the first instance, confirmed in writing by the Variation form (SS8046).

4.2 The Service User may terminate the Individual Service Order on 6 hours' notice, but must inform their Social Worker before taking action. If such action is taken the Council shall pay the Provider for two days' Service.

4.3 The Provider must give at least 5 working days' notice of termination of an Individual Service Order. If 5 working days' notice is not given then the Council may deduct costs incurred in arranging for the Service to be carried out by an alternative Provider/or its own staff together with the administrative costs of making such arrangements. The Authorised Officer's certification of such copy shall be final and binding and the amount so certified shall be deducted from any payment to the Provider under the Agreement or recovered as a debt.

5. TERMINATION OF AN INDIVIDUAL SERVICE ORDER (HOME SUPPORT) UNDER HEALTH & SAFETY

5.1 The Provider may terminate an Individual Service Order where the Service User or a third party associated with the Service User becomes violent or unduly disruptive to such an extent that the Care Worker is prevented from delivering the Service for reasons of health and safety (as provided in health and safety Legislation) or is put at risk of serious physical danger.

5.2 In such a situation, the Provider must notify the Council immediately of the situation and confirm the position in writing within one working day of the cessation of the Service.

6. TERMINATION OF AN INDIVIDUAL PLACEMENT AGREEMENT (CARE HOMES)

6.1 Any of the Parties may terminate an Individual Placement Agreement during a Trial Period on 7 days notice (all notices should be in writing). Where the Council or the Council Service User gives such notice, the Council will pay the fees for the full seven-day period. Where the Provider gives such notice the fee for the actual period of residence will be paid.

6.2 In the case of an Inappropriate Placement, the period of notice will be 7 days and the fee will only be paid for the actual period of residence by the Service User.

6.3 In all other cases (i.e. other than a Trial Period, Temporary Placement, and the closure of the Care Home or an Inappropriate Placement) any of the parties may give 14 days' notice to terminate the Individual Placement Agreement in respect of any individual Service User. Where the Council or the Service User gives such notice, the Council will pay the fee for 14 days. Where the Provider gives such notice the fee will only be paid for the actual period of residence of the Service User.

- 6.4 When a Care Home closes the Provider shall give 3 months' notice for each Service User residing at the Care Home [and the Provider shall be paid the fee in relation to each Service User for the actual period of residence of that Service User or for three months, whichever is shorter].
- 6.6 In the case of the Service User discharging himself or herself, the first day of that the discharge occurs will be deemed to be the first day of the period of notice applicable to that Individual Placement Agreement.
- 6.7 A notice of termination of an Individual Placement Agreement may only be given under in the following circumstances:
- 6.7.1 The Service User may give notice of termination for any reason;
- 6.7.2 The Provider may give notice of termination only for a good reason, including and without limitation, if it is unable to provide the care required to meet the Council Service User's needs following a Support Plan Review of such needs but excluding any reason related to cost and/or the fee.
- 6.7.3 Notice of termination by the Council should wherever reasonably practicable be given with the agreement of the Service User.
- 6.7.4 When in the opinion of the Council the needs of the Council Service User have changed in such a way that the well-being of the Council Service User can best be served by relocation to a place better able to meet his/her current needs, the Council reserves the right to give notice of such relocation to the Service User and the Provider.
- 6.7.5 The Council may give notice of termination where an Inappropriate Placement has been made.

7. TERMINATION OF THE FRAMEWORK AGREEMENT

- 7.1 This Agreement shall terminate upon the expiry of the Contract Period or upon either party giving not less than 3 months' notice in writing to the other parties, whichever is the earlier.
- 7.2 During any period of notice of termination or within the period of three months' prior to the end of the Contract Period the parties undertake to co-operate to ensure that the interests of the Service Users will be met under whatever new arrangements may be proposed.
- 7.3 The Council may terminate this Agreement immediately and upon service of a written notice in the following circumstances:
- 7.3.1 subject to Schedule 9, where the Provider has committed a material breach of the terms of this Agreement provided that where such breach is capable of remedy the Council shall give notice to the Provider requiring it to remedy the breach within a reasonable time period. If the Provider fails to remedy the breach within the time period specified the Council may terminate this Agreement with immediate effect.

- 7.3.2 If the Provider:
- 7.3.2.1 becomes bankrupt, or makes a composition or arrangements with its creditors, or has a proposal in respect of its company or association or organisation for voluntary composition of debts, or scheme or arrangements approved in accordance with the Insolvency Act 1986.
 - 7.3.2.2 has made an application under the Insolvency Act 1986 to the court for the appointment of an administrator.
 - 7.3.2.3 has a winding-up order made (except for the purposes of amalgamation or reconstruction), or a resolution for voluntary winding-up passed.
 - 7.3.2.4 has a provisional liquidator, receiver or manager as defined in the Insolvency Act 1986 appointed.
 - 7.3.2.5 has an administrative receiver, as defined in the Insolvency Act 1986 appointed.
 - 7.3.2.6 has possession taken by or on behalf of the holder of any debentures secured by a floating charge, of any property subject to the floating charge.
 - 7.3.3 Where the Provider ceases to carry on the Care Home under the Care Standards 2000 Act or voluntarily closes the Care Home or ceases to be registered.
 - 7.3.4 Where the Council is reasonably satisfied that abuse has resulted in serious harm or death of a Service User or other resident for which the Provider was responsible.
 - 7.3.5 The Provider has assigned this Agreement without the written permission of the Council.
 - 7.3.6 if the Provider takes unreasonable financial advantage of its relationship with the Service User.
 - 7.3.7 where the Provider or any of its Care Workers engaged in providing the Service is convicted of an offence under the Care Standards Act 2000 or any other relevant Legislation.
 - 7.3.8 Where the Provider ceases to carry on the Service due to voluntary cessation of its business.
 - 7.3.9 Where the Council determines in its sole discretion that continuation of the Contract would cause risk to life, health or well-being of any Service User; or
 - 7.3.10 If the Provider takes unreasonable financial advantage of the relationship with the Service User, or if the Authorised

Officer believes that unreasonable financial advantage has been taken.

- 7.4 During the period of notice both parties shall co-operate to ensure that the interests of Service Users will be met under whatever new arrangements may be proposed. Failure to give adequate notice on the part of the Provider will result in the costs of making alternative care arrangements being deducted from any outstanding payments.
- 7.5 The termination of all Individual Agreements by a Provider shall not be accepted as a method of terminating the Agreement.
- 7.6 The Council may terminate the Agreement immediately, without notice, where there is proven serious abuse or where through the action or inaction of the Provider and their staff a Service User or other resident for whom the Provider was responsible, has suffered serious harm or death.
- 7.7 The Council shall be entitled to cancel the Agreement and to recover from the Provider the amount of any loss resulting from such cancellation:-
- 7.7.1 If the Provider shall have:-
- 7.7.1.1 offered, promised or given a financial or other advantage to another person; and either
- 7.7.1.2 the Provider intends the advantage to induce a person to perform improperly a relevant function or activity in relation to the obtaining or execution of the Agreement or any other contract with the Council; or
- 7.7.1.3 the Provider knows or believes that the acceptance of the advantage would itself constitute the improper performance of the relevant function or activity in relation to the obtaining or execution of the Agreement or any other contract with the Council; or
- 7.7.2 If the like act or acts shall have been done by any person employed by the Provider or associated with the Provider (whether with or without the knowledge of the Provider; or
- 7.7.3 If in relation to any contract with the Council the Provider or any person employed by the Provider or associated with the Provider shall have:-
- 7.7.3.1 committed an offence or offences under the Bribery Act 2010; or
- 7.7.3.2 given any fee or reward to an officer of the Council the acceptance of which is an offence under Section 117(2) Local Government Act 1972.

8. TERMINATION OF A RESPITE OR TEMPORARY PLACEMENT

- 8.1 The period of notice will be 7 days or the remaining period of the Temporary Placement whichever is shorter.
- 8.2 Where the Council or the Service User who is temporarily placed give such notice, the Council will pay the fee for the full seven day period. Where the Provider gives such notice the fee will only be paid for the actual period of residence.

SCHEDULE 9 – CONTRACT MANAGEMENT AND SUPPLIER RELATIONSHIP MANAGEMENT (SRM)

1. Performance - Contract Management and Supplier Relationship Management (SRM)
 - 1.1. The key objectives of SRM and contract management are to ensure that Providers actively engage with the Council and health colleagues in order to:-
 - 1.1.1. provide Services of an acceptable quality with processes for continuous improvement;
 - 1.1.2. provide safe Services;
 - 1.1.3. support Service Users in meeting their assessed needs and identified outcomes;
 - 1.1.4. understand that it is also their responsibility to monitor the quality of their own Service; and
 - 1.1.5. collect market intelligence data.
 - 1.2. The monitoring of a Provider's performance will form part of a wider Supplier Relationship Management (SRM) approach which is about developing two-way, mutually beneficial relationships with Providers which deliver greater levels of innovation and efficiencies at a service delivery level, whilst also ensuring appropriate standards of service for Service Users.
 - 1.3. The Provider's provision of Services under this Framework Agreement and the Individual Agreements [and Third Party Contracts] shall be continuously monitored by the Council against the required outcomes for the Service which are defined in the Service Specifications and the requirements of Service Users' Support Plan.
 - 1.4. The Council shall use a common "Performance Model" to structure the assessment of provider performance at service, provider, category and market levels. This approach shall inform the Council's SRM approach, enabling it to undertake performance and risk assessments at category and market level.
 - 1.5. The Performance Model shall be sub-divided into three key performance areas:
 - 1.5.1. Performance – assessment as to whether the provider is delivering against an agreed set of outputs and outcomes. It will also assess whether the outputs and outcomes delivered meet Safeguarding protocols.
 - 1.5.2. Quality – This will be measured through citizen feedback and the Self-Assessment (SAF) process.
 - 1.5.3. Compliance – evidence of providers meeting contractual and framework agreement requirements e.g. financial viability

requirements, insurance obligations, statutory and regulatory compliance, up to date accreditations.

1.5.4. The Performance Model will specify the information that the Council will collect regarding provider service delivery.

1.5.5. The Performance model will be reviewed by the Council on an annual basis.

2. Supplier Self Assessment (Outline requirements can be found at www.birmingham.gov.uk/shapingthemarket)

2.1. The Provider must submit to the Council a self assessment of its performance on a quarterly basis. The Provider will submit this electronically.

2.2. Failure by the Provider to submit a self assessment on time will effect its ranking, unless the Provider provides a legitimate reason for this failure which is acceptable to the Council.

3. Contract Review

3.1. The Council shall undertake a review of the Provider's performance of the Service (in whole or in part) under this Framework Agreement and any Individual Agreement., a minimum of one review annually.

3.2. The Provider shall meet with the Authorised Officer at a frequency to be decided by the Council to review and discuss the Provider's performance of the Individual Agreement(s).

3.3. Where the Council:

3.3.1. has received notification of concerns relating to the performance of the Individual Agreements (s), the Council may (at its sole discretion and provided that it acts reasonably) require the Provider to attend a Contract Review meeting without prior notification and the Provider shall comply diligently with any such request.

3.4. The Provider shall also attend additional meetings or events as and when requested to do so by the Council as part of any Contract Review (provided that it acts reasonably).

3.5. Notwithstanding clause 3.3, the Council shall also be entitled to initiate a Contract Review at any time during the term of this Agreement in response to:

3.5.1. any breach of the terms of the Agreement or any Individual Agreement by the Provider; and/or

3.5.2. any representations or complaint which is received by the Council with regard to (in any of such cases) the Provider's performance of the Framework Agreement (or any part of it) and any Individual Agreement.

3.6. The Provider shall (at its own expense) afford all reasonable cooperation, resources, reports, paperwork and facilities to enable the Council to carry out Contract Reviews without interference and shall provide to the Council all information which is required by it (acting reasonably) for such purposes.

4. Concerns regarding the performance of a Provider

4.1. The Council may wish to investigate a concern or an alleged breach of the Framework Agreement or Individual Agreement, or any other event including force majeure, which if substantiated would entitle the Council to terminate the Framework Agreement or Individual Agreement.

4.2. Failure by the Provider to maintain the required standards of the provision of the Service may be considered a breach of the Framework Agreement and the Council shall be entitled to follow any of the contract management actions as detailed in Section 5 below.

5. Contract Management Actions

5.1. The Authorised Officer may undertake any of the following actions (in no particular order) where a concern or an alleged breach of this Agreement or any Individual Agreement has been identified:

5.1.1. Contract Management Meeting

5.1.1.1. The Provider may be invited to a contract management meeting to consider any concerns raised and identify a course of action.

5.1.1.2. Depending on the concern, the meeting may be led by a health professional where the concern is specific to clinical (nursing) services.

5.1.1.3. As part of the Contract Management Meeting, one or more of the following courses of action may be taken:-

5.1.1.3.1. No further action because the concern(s) are unfounded or resolved.

5.1.1.3.2. The Authorised Officer and Provider will jointly agree a Improvement Plan in order to support the Provider and address the specific concerns about both the delivery of the services and the party's obligations under the Agreement. The Improvement Plan will be specific, measurable, achievable, relevant and time bound. This plan should be received by the Council within 10 working days. The implementation targets within the Improvement Plan should not exceed 60 working days and the Council will undertake at least one associated monitoring visit during this 60 day period.

- 5.1.1.3.3. Suspension of further Individual Agreements in accordance with section 6 of this Schedule 9.
 - 5.1.1.3.4. A notice of breach of the Agreement is issued in accordance with paragraph 6.3 of this Schedule 9.
 - 5.1.1.3.5. Termination of the Individual Agreement and/or Framework Agreement in accordance with Schedule 8 (Non Take up of the Service, Absence of the Service User, Notice Periods and Termination and Related Payments).
- 5.1.1.4. Progress against the Improvement Plan will be reviewed after 30 working days (or sooner in agreement with the Provider), to ensure the Provider is making the appropriate/agreed improvement(s).
- 5.1.1.5. Following the initial meeting and actions, a review meeting will be undertaken. As a result of that review meeting one or more of the following courses of action may be taken:-
- 5.1.1.5.1. Concern(s) are satisfactorily addressed and the issue is deemed to be closed.
 - 5.1.1.5.2. Remove suspension (if applicable).
 - 5.1.1.5.3. Recommendations made for further improvement by the Provider via agreement of a further Improvement Plan.
 - 5.1.1.5.4. Continue suspension for a further period, but for no longer than a period that would amount to the Provider being suspended for more than 90 working days in total..
 - 5.1.1.5.5. A notice of breach of the Agreement is issued in accordance with paragraph 6.7 of this Schedule 9.
 - 5.1.1.5.6. Termination of Individual Agreement and/or Framework Agreement in accordance with Schedule 8 (Non Take up of the Service, Absence of the Service User, Notice Periods and Termination and Related Payments).

6. Suspension

- 6.1. The Council may decide to suspend any further Individual Agreements with a Provider following a Contract Management meeting. In extreme cases, there may be a need for an immediate suspension where there are serious concerns in relation to risks to health, safety and/or the welfare of citizens which cannot be immediately remedied.
- 6.2. This suspension may be issued with conditions and/or restrictions attached (for example suspension of all or part of the service) for any of the following reasons:-
 - 6.2.1 The Authorised Officer may wish to investigate any concerns that there may be which imposes an immediate and/or serious threat to the health & safety and/or welfare of any Service User;
 - 6.2.2 If the Authorised Officer wishes to investigate any alleged breach of this Agreement or an issue relating to an Individual Agreement or any other event which, if substantiated, would entitle the Council to terminate the Agreement;
 - 6.2.3 Where the Provider breaches any term or condition of this Agreement, or fails to fulfil any obligation required under an Individual Agreement;
 - 6.2.4 The Provider has failed or is failing to address the concerns identified in the Improvement Plan;
 - 6.2.5 A performance failure has been identified through monitoring the quality of service by the Council;
 - 6.2.6 There are documented systemic failures within the respective Service
- 6.3 Where a suspension is issued, the Council will notify the Provider in writing of its decision to suspend any further Individual Agreement(s) and the reasons for this, within two working days of such decision being made.
- 6.4 The Provider is expected to inform all Service Users (including self funders) and their representatives of the Suspension of further Individual Agreement(s).
- 6.5 The Provider is expected to inform all Service Users (including self funders) and their representatives of the lifting of Suspension arrangements..
- 6.6 The Suspension may be reviewed at any time.
- 6.7 Breach of the Agreement:-
 - 6.7.1 A Breach Notice may be issued at any time where the Council has reasonable evidence that the performance of the Provider materially fails to meet the requirements of this Agreement.
 - 6.7.2 The Council may issue a Breach Notice at any time, setting out the performance deficiency, the action required to rectify it and timescales. If requirements are not responded to within the

timescales set, the Council will consider whether it wishes to continue with its specific business relationship with the Provider and may terminate this Agreement subject to Schedule 8 (Non Take up of the Service, Absence of the Service User, Notice Periods, Termination and Related Payments).

6.8 Termination

The Council may terminate this Agreement or an individual agreement in accordance with the requirements of Schedule 8 (Non take up of the Service, Absence of the Service User, Notice Periods, Termination and Related Payments) of this Framework Agreement.

SCHEDULE 10 - JOBS, SKILLS AND SUPPLY-CHAIN OPPORTUNITIES

1. Partnership Benefits

- 1.1 As a means of delivering its commitments in the Sustainable Community Strategy the City Council has adopted a Procurement Policy for Jobs and Skills. To implement the policy commitments the Council's Adults and Communities Services is committed to working in partnership with Providers to maximise the recruitment and training of new entrants to the care industry based in and around the area where the care is being delivered. The Council's aspiration is that opportunities for `new entrant trainee` will be 10% of the full-time equivalent (fte) staff delivering Services within Birmingham. This will also ensure that there is an expanding local workforce (with accredited skills) that all contractors can recruit from, and that the costs of training and personal development are shared.

2. Targeted Recruitment and Training Activities

- 2.2 All Providers are expected to provide a Jobs and Skills Method Statement as part of their Framework Contract application. Providers are advised to look at the local economic benefit information sheet included here as Appendix 1. This will give information on local training, job-matching and supplier development organisations and resources.
- 2.3 The Method Statement could include information on:
- 2.3.1 The type of `new entrant trainee` opportunities to be provided;
 - 2.3.2 the training to be provided to each new entrant trainee;
 - 2.3.3 the names of organisations agreed by the Council through which the new entrant's trainee will be recruited;
 - 2.3.4 the names of training organisations that will provide training to Care Quality Commission standards.

3. Monitoring Information

- 3.1. To assist the Council to verify information provided in the Quality Assessment Framework the Providers will be required to:
- 3.1.1 provide a Quarterly list of the new entrant trainees that started their employment in the quarter.
 - 3.1.2 provide a Quarterly statement of training outcomes that lists the accreditation achieved by each new entrant trainee by name in the Quarter;
 - 3.1.3 provide an annual statement, verified by the Service Provider's independent auditors, of the fte staff used by the Provider in the year to service Birmingham contracts

4. Notification of Vacancies

- 4.1 Every vacancy for staff that will work on the contract (and for residential care around facilities used to deliver the contract), shall be notified to the Council's Employment Access Team (Tel 0121 464 2112 e-mail eateam@Birmingham.gov.uk) and other agencies agreed by the Council.

Candidates identified by these agencies are to have an equality of opportunity in the selection process.

5. Supply-chain Opportunities

- 5.1 The Council has established Find it in Birmingham (FiiB) as a free portal site that can facilitate inter-trading between organisations operating in the City and enable contractors and Service Providers to the Council to maximise supply-chain opportunities for local companies.
- 5.2 Providers are encouraged to notify FiiB of all sub-contract and supply opportunities and assist local companies to develop competitive services and tender/pricing submissions.

Contact: www.finditinbirmingham.com

Appendix 1 - Local Economic Benefit Information Sheet

Employer Offer

Birmingham City Council, in Partnership with Jobcentre Plus and the Skills Funding Agency offers a free support service for businesses from all sectors to meet staff training and recruitment needs. The service is co-ordinated by Birmingham City Council's Employment Access Team (EAT Team), who can be contacted to find out about a range of support and services, including:

- Bespoke recruitment campaigns, including management of campaigns
- Skills assessment and job matching of candidates to vacancies
- Pre-employment training
- Post employment support, including retraining staff
- Signposting to sources of funding for additional training and apprenticeships

EAT Team contact details:

Employment Access Team
Development Directorate
Birmingham City Council
PO Box 2470
Birmingham B1 1TR
Telephone: 0121 464 2112
Email: eateam@Birmingham.gov.uk

Partnership Websites

The EAT Team: www.Birmingham.gov.uk/eat
Jobcentreplus: www.dwp.gov.uk/jobcentreplus
The Skills Funding Agency: www.skillsfundingagency.bis.gov.uk

Current support schemes

Train to Gain

This is a national service that offers impartial, independent advice about training and development to improve the skills of employees and ultimately, to improve business performance. The service also includes advice on access to funding. In Birmingham this service is delivered by Business Link West Midlands. For more information please visit the website:
www.Traintogain.gov.uk

Apprenticeships

Apprenticeships are work-based training programmes designed around the needs of employers, which lead to national recognised qualifications. The National Apprenticeship Service helps to fund this training. For more information contact the National apprenticeships Service on: 08000 150 600 or visit the website:
www.apprenticeships.org.uk

Graduate Internships

Graduate Talent Pool is a new service, designed to help match the skills businesses require with those offered by new and recent graduates. You can advertise internship opportunities for free, directly to graduates by visiting:

www.graduatetalentpool.direct.gov.uk.

Work Trials

The work trial initiative offered by the jobcentre allows potential recruits the opportunity to demonstrate their suitability for a job with an employer before committing themselves to moving from benefits to employment. For more information visit www.direct.gov.uk and search for work trials.

Please note all information provided in this information sheet is correct at the time it was written and may be subject to change.

SCHEDULE 11 –SAFEGUARDING SPECIFICATION

1. The provider is expected to demonstrate compliance with CQC Essential Standards of Quality and Safety, outcome 7: 'Safeguarding people who use services from abuse', and Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
2. The Provider is expected to demonstrate compliance with the Birmingham Safeguarding Board (BSAB) Multi Agency Safeguarding Guidelines (<http://www.bsab.org/>)
3. Providers will:
 - Have a clearly stated policy commitment to work to BSAB guidelines/vision for the implementation of safeguarding systems across the city
 - Raise multi-agency alerts promptly in cases where abuse is suspected and:
 - Attend/contribute to Safeguarding meetings as required
 - Share relevant information in line with BSAB guidance.
 - Contribute to any safeguarding plans drawn up to protect adults at risk.
 - Co-operate and engage fully with the Safeguarding process and document involvement as required.
 - Have a clearly stated policy commitment to deliver on the 'Dignity and Respect' agenda, covering how staff interact with users of their service.
 - Have a policy statement on the application of the Mental Capacity Act 2005 principles. In cases where Vulnerable Adults lack mental capacity, the Provider must demonstrably work within the framework of the Mental Capacity Act 2005 at all times - evidencing how capacity has been assessed and how best interests decisions have been reached, and demonstrating that the Provider has made every effort to maximise the Vulnerable Adults ability to make decisions for themselves wherever possible.
 - The Provider should have a policy statement on the application of the Deprivation of Liberty Safeguards and must evidence full compliance with statutory requirements around DoLS in cases where occasional restraint has become an ongoing deprivation of liberty.
 - The Provider must have a policy statement on the use of restraint, recognising the many different forms restraint can take. This will include a commitment to minimum intervention and best interests where there is any intervention of restraint and:
 - The Provider should record each occasion in which any form of restraint has needed to be used, and evidence that any such use of restraint has been appropriate and proportionate.
 - Where the use of restraint is ongoing, clear guidelines, risk assessment and management plans should be made explicit in individual care plans.

- Provide evidence of reflection and learning following incidents, of consultation with relevant professionals, and of adopting preventative strategies wherever possible.
4. The Provider must promote a culture of awareness around safeguarding issues, dignity and respect, and Mental Capacity. This not solely within the staff group but also with Service Users, carers and visitors; making reference to Safeguarding processes and to it's commitment to a multi agency response to suspected abuse in its promotional literature, complaints procedures, Service User guides and so on.
 5. The Provider will demonstrate commitment to training leading to informed and improved practice. The Provider will have a comprehensive Safeguarding training programme which should include elements of: Restraint, Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS), and 'Dignity and Respect', and are covered in. This programme should be delivered as part as:
 - the Employee training programme
 - induction programme for all new Employees
 - ensure Employees receive more enhanced Safeguarding training within the first year of employment
 - ensure all Employees undertake refresher training at least once every three years thereafter.
 6. Providers can access further information, reference documents and materials relating to Safeguarding via <http://www.bsab.org/>

Measures

Appropriate referrals

Employee knowledge of Safeguarding and Safeguarding process

Employee knowledge of restraint, DoLS, MCA and appropriate Implementation

ADDITIONS FOR THE GLOSSARY / DEFINITIONS OF TERMS:

Vulnerable Adult:

Birmingham Safeguarding Adults Board (BSAB) defines a Vulnerable Adult as being a person who is:

- Aged 18 years or over
- Who is or may be in need of community care services because of frailty, learning or physical or sensory or mental health issues

- Who is or may be unable to take care of him or herself, or take steps to protect him or herself from significant harm or exploitation

Abuse:

Abuse is any action that harms another person or infringes their human rights. This can include:

- Physical abuse such as hitting, burning, pushing or kicking someone
- Verbal abuse such as shouting or swearing
- Emotional abuse such as bullying, taunting, threatening or humiliating someone
- Sexual abuse such as inappropriate touching or forcing someone to take part in or witness any sexual act against their will
- Financial abuse such as misusing, keeping or taking someone's money, property or other belongings without their agreement
- Neglect such as not providing necessary food, heating, care or medicine
- Discrimination such as ill-treatment or harassment based on a person's age, sex, sexuality, disability, religious beliefs or ethnic group.

Mental Capacity Act Principles

The Mental Capacity Act is underpinned by five key principles (Section 1, MCA):

Principle 1:

A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

Principle 2:

Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

Principle 3:

Unwise decisions – people have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

Principle 4:

Best interests – anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

Principle 5:

Less restrictive option – someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

Mental Capacity

Having mental capacity means that a person is able to make their own decisions. You should always start from the assumption that the person has the capacity to make the decision in question (principle 1). You should also be able to show that you have made every effort to encourage and support the person to make the decision themselves (principle 2). You must also remember that if a person makes a decision which you consider eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3). Under the MCA, you are required to make an assessment of capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be. You might need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness or disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone.

SCHEDULE 12 – MEDICINES MANAGEMENT FOR HOME SUPPORT SERVICES

1. Policy For Administering Medication

1.1. All Provider medicine management policies and procedures should document the usual practice of the Provider (prescribed and PRN). The following must be included but is not exhaustive:

- 1.1.1. Adults receiving Home Support services will be responsible for administering their own medications in many circumstances and where possible should be encouraged to retain their independence by doing so.
- 1.1.2. The Service User requires a Home Support Service for other tasks as well as medication and the Service User has no one else to administer medication.
- 1.1.3. The Service User cannot direct someone else to administer medication.
- 1.1.4. The Support Plan process states medication is a requirement within the Support Plan.
- 1.1.5. Compliance aids to self administer medication have been explored.
- 1.1.6. The level of support must be documented and reviewed on an individual basis.
- 1.1.7. Service Users in receipt of care from multiple agencies have a written agreement in place to identify which Provider holds the responsibility for assistance with medication.
- 1.1.8. Home Support worker may administer medication only after they have received training in line with the Care Quality Commission's requirements and are following the procedure set out in this document

2. Procedures and Requirements

2.1. Providers must ensure the following requirements are met and that care staff follow all the following procedures:

- 2.1.1. Read the medication agreement for each individual Service User which must be available in the Service User's home.
- 2.1.2. Follow strict hygiene rules in respect of thoroughly washing hands before and after assisting with medication.
- 2.1.3. Check all instruction on every visit thoroughly before administering medication.
- 2.1.4. Avoid handling medication directly and give to Service Users in a galipot to take.
- 2.1.5. Follow instructions and give Service Users water/drinks to be taken

with medication where appropriate.

- 2.1.6. Record clearly any medication taken, refused, and spilt.
- 2.1.7. Only care staff that ARE competent and required to give medication should administer and record, sign and date the administration record.
- 2.1.8. Medication refused should be reported immediately to the Manager.
- 2.1.9. All care staff involved in assisting with medication must register and sign a sample signature for medication recording.
- 2.1.10. Care staff must not leave medication out to take later.
- 2.1.11. The Medication agreement must state who has responsibility for ordering, collection and administration of Medication.
- 2.1.12. The agreement must clearly state where the medication must be kept if the medication has to be stored securely details of procedure must be available to staff responsible to assisting with medication.
- 2.1.13. Providers must ensure that safe return and disposal of medicines is recorded and incorporated within the policy.
- 2.1.14. In no circumstances should Providers remove or dispose of medication and records.
- 2.1.15. Providers must ensure that senior staff reviews all Service Users needing support with medication on a monthly basis to ensure staff are adhering to the policy.
- 2.1.16. Changes and errors relating to medication must be reported to the Care Coordinator..
- 2.1.17. Refresher training must be updated to maintain competencies.
- 2.1.18. Providers must attend safeguarding meetings in relation to medication issues.
- 2.1.19. All medication records/MAR sheets must be clear and legible and include all Medication to be given, timing of medication, type of medicine given, storage details, dates and signatures.

3. General Guidance For All Providers

- 3.1. All medicines must be in a monitored dosage system or in the container issued by the dispensing Pharmacist and labelled with:
 - 3.1.1. The Service User's name
 - 3.1.2. The name of the medication
 - 3.1.3. Dosage and strength of medication
 - 3.1.4. Frequency and time to be given

3.1.5. Date issued by the dispensing Pharmacist

3.2. Liquid medication must only be administered using a measured galipot.

3.3. No 'over the counter' medicines e.g. cough medicine; paracetamol should be purchased or administered by the Home Support Service unless they are prescribed by a GP.

3.4. The Home Support Service will only administer medication obtained on a prescription and dispensed by a pharmacist into a tamper proof Monitored Dosage System and appropriately labelled.

3.5. The only exception to a monitored dosage system is when a short course of medication is prescribed, (10 days or less).

4. Hospital Discharge

4.1. Providers must ensure that a plan is in place to support care workers to assist with medication on discharge from Hospital, if the medication required differs from the assessment prior to hospital admission.

5. Errors In Administration Of Medication

5.1. In the event that medication errors occur, missed doses, wrong medication given the Provider shall immediately:

5.1.1. Contact the Service User's GP to seek advice

5.1.2. Follow policy and procedures

5.1.3. Inform the family/relative

5.1.4. Inform the duty social work team or the Emergency Duty Team (EDT)

5.1.5. Complete a multi agency safeguarding alert and forward to appropriate team

5.1.6. Relevant documentation to be completed and records of all activities must be available on request by the Council or PCT.

6. Training Requirements For Staff Administering Medication

6.1. Providers must ensure all care staff involved in administering medication is trained and competent to complete the task, which includes any specialist tasks.

6.2. Training must include as a minimum:

6.2.1. Preparing dosages if liquid medication is required.

6.2.2. Administering medication including tablets, capsules, liquid medication given by mouth, ear, eye and nasal drops, inhalers and external applications. The Home Support worker must be trained by a Healthcare Professional.

- 6.2.3. Non prescribed or alternative medicines.
- 6.2.4. Checking all instructions including the storage of medication/ medication documentation at each visit to ensure correct medication is given to the correct person whom they were prescribed for including checking dosage, timing and method.
- 6.2.5. Checking the expiry date of medication has not exceeded
- 6.2.6. Checking medication has not already been given, for example by family members
- 6.2.7. Observing changes or side effects from the Service User and reporting.
- 6.2.8. Record all medication given
- 6.2.9. Recording and reporting any refusals and medication errors immediately to managers.
- 6.2.10. Procedure for support with painkillers and other medicine not written into the care plan.
- 6.2.11. Understanding the Policy, including changes following hospital discharge and the individual's medication agreement and collection of medicines.
- 6.2.12. Risk Assessments for medication.
- 6.2.13. Care Quality Commission's policies for the administration of medication.

SCHEDULE 13 - MEDICINES MANAGEMENT IN CARE HOMES

1. All medicine management policies and procedures should document the usual practice of the home. The following must be included, but is not exhaustive:

1.1. Ordering and recording of medicines

- 1.1.1. Consent from the Service User for care staff to handle their medicines must be documented.
- 1.1.2. A documented system must be in place to identify the current medical practitioner responsible for the care of each of the Service Users, and the current community pharmacy that provides the medication for the Service Users within the home.
- 1.1.3. A robust system must exist to ensure medicines are ordered sufficiently early to allow for prescriptions to be checked before administering and there is demonstrable evidence of a clear audit trail of receipt of all medicines.
- 1.1.4. The ordering process must ensure minimal waste.
- 1.1.5. A system must exist to rapidly obtain medication in an emergency.
- 1.1.6. Each medicine received must be recorded on the Service User's Medication Administration Record (MAR) chart.
- 1.1.7. There must be a robust process to ensure that controlled drug balances are correct and there is a written procedure which states actions to be taken if balances do not tally.
- 1.1.8. The controlled drug register must be a bound book, completed in indelible ink with no crossings out. A running total must be kept and the balances checked regularly. The contents page should allow access to the correct page for the Service User.

1.2. Storage of medicines

- 1.2.1. The storage area(s) must be of adequate size. Medicines cupboards should be well-labelled and organised to make medication easy to find. The area(s) must be neat, clean and tidy. The temperature of the storage area(s) should be maintained and must not exceed 25°C min temperature
- 1.2.2. All medicine storage facilities should be locked and secure at all times. Moveable drug trolleys must be fixed to the wall when not in use. All medicines keys (drug cupboard/trolley(s) and CD keys) should be held by a designated person.
- 1.2.3. There must be evidence of stock rotation and carrying forward of medication to reduce waste.
- 1.2.4. Medicines requiring refrigeration must be stored separately from food.

- 1.2.5. Fridge temperatures must be recorded daily. Fridges must be defrosted monthly and procedures in place that detail what action must be taken if fridges go outside 2-8 0 C or if the fridge fails. The procedure must include contacting a pharmacist for advice about stability of the medicines.
- 1.2.6. The CD cupboard must comply with legal regulations. It must be made of metal and attached to a substantial wall. It must be kept locked.
- 1.2.7. All keys must be easily identified and stored appropriately.
- 1.2.8. Under normal circumstances, a maximum of 2 months stock (or one spare original pack if this is more) should be held at any one time (including catheters, dressings and as required medicines).

1.3. Administration of medicines

- 1.3.1 Photos (if used) must be in colour and regularly updated as needed and at least every 12 months.
- 1.3.2 Documents where Service Users have similar names must be highlighted.
- 1.3.3 Self administration must be encouraged and supported with appropriate assessment, systems and risk assessment.
- 1.3.4 All medication and preparations including nutritional supplementation feeds, dressings and creams should only be administered to the named Service User for whom it is prescribed.
- 1.3.5 Topical medicines (including creams, eye and ear preparations) should be dated when opened.
- 1.3.6 All medications must be in date and there must be a robust process to ensure that only in date medicines are administered.
- 1.3.7 Covert administration must be in accordance with professional and legal codes and clearly documented.
- 1.3.8 Administration of PRN medication must be for the specified indication documented on the MAR chart and in accordance with the PRN protocol. This must also be referred to in the Service User's Care Plan.
- 1.3.9 Each medicine that a Service User is currently taking should be detailed within their This must include as a minimum:
 - 1.3.9.1 The name of the medicine
 - 1.3.9.2 The indication
 - 1.3.9.3 The dose and directions for use
 - 1.3.9.4 Common side effects
 - 1.3.9.5 Any special requirements or monitoring needed

- 1.3.10 The file holding the MAR charts should be clean and functional. MAR charts should be punched so entries are legible and kept in a condition that enables them to stay in the file.
- 1.3.11 Dividers between Service User's MAR charts are robust and present for every Service User.
- 1.3.12 There should be a list of staff signatures in each MAR chart file.
- 1.3.13 Service User allergies must be recorded in a consistent place which is prominent when administering medicines and the pharmacist who provides medication to the Care Home should be aware of these allergies
- 1.3.14 MAR charts should be used to record all medication taken or used by the Service User. This includes prescribed and bought medicines, homely remedies, topical preparations, nutritional supplementation feeds, catheters and dressings.
- 1.3.15 MAR charts must be clear, legible and are usually computer generated. If a new drug is added mid cycle or if a Service User is new, it is reasonable for the new medication to be hand-written on to the MAR chart. If hand-written this should be legible, written by a nurse or appropriately trained senior member of staff and checked by a further senior member of staff. Both should sign each hand-written entry on the MAR chart.
- 1.3.16 Codes on MAR charts must be understandable and used appropriately.
- 1.3.17 Medication not in use but still on MAR chart should be crossed off and signed.
- 1.3.18 All in date and clearly identifiable unused or partly used PRN medicines should be carried forward for use in the following month. The quantity carried forward must be recorded on the MAR chart and should be used to determine whether a new order is required or not.
- 1.3.19 Unused or partly used emollients and inhalers should also be carried forward for use in the following month.
- 1.3.20 Medicated creams and ointments however, must not be carried forward.
- 1.3.21 Photocopies of latest batch of prescriptions must be kept with the MAR chart for each Service User or there must be another suitable system in place for accessing copy prescriptions. These should be used to check the relevant MAR charts and medicines dispensed for accuracy and any discrepancies found addressed before administration.
- 1.3.22 Interruptions during drug rounds must be kept to a minimum.

2. Disposal of medicines

- 2.1 Recording and disposal of medicines including controlled drugs and sharps must be in accordance with both the law and professional codes of conduct.

3. Medication errors and adverse events

- 3.1 Processes must be in place for recording and acting upon errors and near misses
- 3.2 Processes must be in place for recording and management of adverse drug events.
- 3.3 There should be a written protocol which details who is responsible for and how to deal with drug alerts/recalls and other information about medicines which require prompt act.
- 3.4 Appropriate and timely actions must be taken and documented for issues about medicines which affect patient care including alerts from the National Patient Safety Association and Safety alert broadcasts.

4. Miscellaneous points

- 4.1 Robust processes must be in place for treatment of minor ailments. (E.g. using a homely remedy protocol). If used, homely remedies protocols must be agreed with patients' GPs. Medicines for homely remedies must be purchased.
- 4.2 Robust processes must be in place for management of gases, which includes information on storage and which conforms to COSHH requirements.
- 4.3 Staff and Service Users should have access to adequate, up-to-date medicines information about the drugs prescribed to individuals. There should be access to an up-to-date BNF, current Service User information leaflets and advice available via the community pharmacist.
- 4.4 All Service Users should have an annual medication review with their clinician requested by the home staff or there should be a robust process to ensure that every Service User is reviewed regularly. The GP should be contacted in the event of any concerns regarding medication.
- 4.5 A robust procedure must be in place for dealing with doses of medication whilst the Service User is away from the Care Home.

5. Training

- 5.1 Staff should be adequately trained to administer medicines safely. CPD/training should be documented.
- 5.2 Medication management update sessions offered to staff should be regularly attended.
- 5.3 There should be a process in the Care Home to check that staff performance in relation to medicines management is adequate.

5.4 Mandatory training for nurses and senior staff and senior healthcare assistants

5.5 Medicines Management including administration, handling and storage of medicines

6. Enhanced Services

1.1. Care Home staff must liaise with pharmacists undertaking work for the Birmingham PCTs in the Care Home

7. Medicines Management Advice from your PCT

- NHS BEN (Birmingham East and North PCT) Tel 0121 333 4113 and ask for medicines management
- NHS South Birmingham (South Birmingham PCT) Tel 0121 465 8099
- NHS HOB (Heart of Birmingham PCT) Tel 0121 224 4051

SCHEDULE 14 – FALLS AND INJURY PREVENTION IN CARE HOMES

PURPOSE

- 1.1 Aims
 - 1.1.1 To reduce the number of avoidable falls
 - 1.1.2 To reduce the number of injuries resulting from falls

EVIDENCE BASE

- 2.1 **An estimated 30% of over 65's each year will experience a fall, which will inevitably have a detrimental effect on the person's well being and independence. These risks increase as age increases.**
- 2.2 A focus on falls and fractures is also strongly supported in the Department of Health Commissioning Toolkit, part of the Older Peoples' Prevention package (2009), which reports the rate of falls in care homes is almost three times that of older people living in the community.

OVERVIEW

- 3.1 Care Providers will put in place robust systems for identifying Service Users at risk of falls and implement care plans that both provide care post a fall and undertake measures to prevent subsequent falls. This will involve analysis of the current pattern of falls (time of day, location, staffing etc) in order to establish particular patterns and trends.

Providers will:
 - 3.1.1 conduct falls risk assessments on all Service Users on Service commencement and ongoing review for falls prevention
 - 3.1.2 ensure accurate and timely recording and reporting of falls to facilitate an audit.
 - 1.1.3 ensure a standardised, systematic approach to falls and injury prevention to ensure equity of care
 - 1.1.4 develop and implement a falls prevention policy that reflects Service User's needs
 - 1.1.5 develop and implement a system of root cause analysis and investigation following a fall and/or injury
 - 1.1.6 ensure there are pre and post fall care plans in place
 - 1.1.7 ensure employees are trained in falls and injury prevention Falls risk assessments and care plans should include:
 - 1.1.7.1 Recording of any known medical reasons which may

cause a fall for example; Infection, constipation, medication, delirium and respond to an increase in falls as appropriate e.g. refer to GP.

- 1.1.7.2 Health and safety checks (consideration of the environment, reducing risk, long corridors, rugs, type of flooring, chair height, blankets, clothing, walking aids)
- 1.1.7.3 Mobility levels Nail/foot care
- 1.1.7.4 Sight: Service Users should have access to eye tests
- 1.1.7.5 Hearing and continence assessments where appropriate
- 1.1.7.6 Risk times for the Service User
- 1.1.7.7 Night waking (consider changing meal times/offer milky drink/snack in the evening)
- 1.1.7.8 Referrals to GPs, other professionals or specialist clinics e.g. falls clinics as appropriate

FALLS AND INJURY PREVENTION MEASURES

- 4.1 To provide standard recording, reporting and management systems related to falls and injuries
- 4.2 To provide an accurate profile of the number of falls that occur
- 4.3 To be able to provide evidence of outcomes of systematic investigations of root cause analysis of fall related incidents

FURTHER INFORMATION

A number of key documents and indicators also support patient safety through the prevention of falls in NHS funded care; High Impact Actions for Nursing and Midwifery (2010), Essence of Care (2010), Nurse Sensitive Indicators and Energising for Excellence

SCHEDULE 15 – EQUIPMENT PROVISION IN CARE HOMES

1. This schedule is produced in line with guidance contained in these Department of Health (DOH) documents:
 - a. Community Equipment and Care Homes (DOH 2004)
 - b. Guidance on NHS Funded Nursing Care (DOH March 2003)
 - c. Care Homes for Older People (DOH 2003)
2. The aims of using equipment effectively are to:
 - a. Help persons maintain or regain their independence
 - b. Support persons to live in the community and thus avoid unnecessary hospital admission
 - c. Slow down deterioration in function
 - d. Prevent further damage/disability
 - e. Support and protect the health of its workforce
3. The aim of this Schedule is to clarify the issue of responsibility and funding for the provision of equipment for Service Users in Care Homes under this Agreement.
4. This schedule describes who is responsible for the provision of a wide range of equipment that may be required, either for a short or longer period of time, by a person within a care home setting.
5. Equipment used to support people in care homes is subject to management under Controls Assurance standards for the “Management of Medical Devices”, all relevant legislation and guidance from the Medical Devices Agency.
6. Providers must:
 - a. adhere to Standard 38 of the National Minimum Standards which implies that the Care Home manager must ensure, so far as is reasonably practicable, the health, safety and welfare of residents and staff. The registered manager will be expected to comply with relevant legislation.
 - b. fund an adequate supply of equipment to meet the twenty four hour care needs of their residents.
 - c. ensure equipment provision should be focussed on client need and provided by the care home if it is the type of equipment that is usually required by its residents.
 - d. fund and provide equipment required for the health and safety of their staff particularly for manual handling purposes

- e. provide equipment based on an assessment of need with the assessor utilising recognised accredited tools and scales, clinical guidance /agreed local protocols, using specific assessment tools for stand aid hoists
- f. ensure all staff assessing for equipment, must be competent and confident, having received appropriate training.
- g. ensure all equipment is be maintained and kept properly decontaminated in accordance with the Health Protection Agency guidance on Infection Control in Nursing Homes (March 2008). Equipment loan stores may offer a decontamination service for an agreed fee.

7. Bespoke Equipment for Named Residents

- a. Bespoke equipment is provided by the Equipment Loans Service for named residents where a resident has needs that are over and above what a care home can be expected to provide as part of its normal service.
- b. The Equipment Loans Service will make it clear where equipment is issued on a single use basis, otherwise all equipment remains the property of the Equipment Loans Service and should be returned when no longer required by the individual for whom it was prescribed.
- c. Assessment and decisions about eligibility must be undertaken by a relevant professional. This will mean requesting input from specialist practitioners from either Primary or secondary care settings.
- d. Specialist equipment should only be used for the person for whom it was originally prescribed.
- e. All specialist equipment used for the care and management of named persons will be subject to review. The frequency of the review should be detailed in the person's care plan together with the name of the person responsible for the review.

The examples listed in the categories of equipment are not exhaustive and will be subject to review by the partner agencies.

Item of Equipment	Care Home Setting		Comments
	Nursing	Non-Nursing	
For Administration of Medicine			
For administration of oral medicine, e.g. measures, medication boxes	CH	CH	Medication via prescription/chemist packs
For administration of rectal medication, e.g. gloves	CH	PCT	Prescription via GP or Nurse Prescriber
For administration of medication by injection including plastics	CH	PCT	
Syringe drivers and disposables e.g. for epidurals	PCT	PCT	See local arrangements Subject to review

Bathing Equipment			
Range of Bath Seats/Boards	CH	CH	
Electric/Manual Bath Lift	CH	CH	
Range of Shower Chairs/Stools	CH	CH	

Beds			
General Beds – under risk management	CH	CH	
Standard Type – fixed beds - high / low beds	CH	CH	CH to provide for general use.
Adjustable height beds including electric profiling beds Low/low beds. It is expected that a ratio of 1:10 beds are provided by the care home with nursing. If there is a trend in a particular care home where there is an increased number of falls there would be an expectation that the number of these beds be increased. Refer to Falls' schedule. All beds in Dementia units should be low/low beds.	CH	CH	CH to provide for general use. PCT to provide if required by PCT staff to enable them to carry out nursing procedures following Risk Assessment and returned when no longer required Profiling beds will be subject to review, Care homes are advised to replace current stock with profiling beds when beds are due for renewal or as needs arise.
Specialist beds including specialist mattresses – e.g. for people with complex treatment and health care needs	PCT	R	PCT R
Bariatric beds	CH & PCT	R	CH & PCT R
			CH to provide bariatric beds at a ratio of 1:15 residents, PCT will provide any requirement exceeding this volume based on individual need.

Bed Attachments			
Range of Backrests	CH	CH	
Rope Ladder	CH	CH	
Range of Bed Raisers	CH	CH	
Over Bed Trolley Table	CH	CH	
Lifting Pole	CH	CH	

Item of Equipment	Care Home Setting		Comments
	Nursing	Non-Nursing	
Bedrails for Divan / Standard / Electric Bed	CH	CH	Extra high bed rails must be used with an alternating airflow mattress if required (MHRA 2006).

Chair Raising & Seating			
Range of Standard Chairs/Seating/Raisers of variable heights to include recliners	CH	CH	PCT recommends that when current seating is renewed it should be replaced with seating that has 'built in' pressure relieving properties
Adult Specialist Seating e.g. bespoke (tailor made) for people with complex treatment and health care needs	PCT	PCT	

Dressing Equipment – EDL			
Small Dressing Aids e.g. Stocking Aid/Tights Aid/Long Handles Shoe Horn	CH	CH	

Help with Feeding					
PEG Feeding Equipment (EL (95)5)	PCT	R	PCT	R	Provided by initiating trust
PEG Feeding Consumables	PCT	R	PCT	R	Provided by initiating trust
For Intravenous Feeding and Transfusion	PCT	R	PCT	R	Provided by initiating trust
Equipment e.g. Plate Accessories	CH		CH		
Range of Feeding Equipment	CH		CH		
Helping Hand	CH		CH		
Trolley	CH		CH		
Backrests to aid nutrition and hydration	CH		CH		

Mobility Equipment					
Metal adjustable walking stick	PCT		PCT		
Walking Frames	PCT		PCT		
Walking Frame Alpha	PCT	R	PCT	R	
Walking Frame Gutter	PCT	R	PCT	R	
Crutches	PCT		PCT		

Gutter Crutches	PCT		PCT		
Delta-Type Walker	PCT	R	PCT	R	
Rollator-Type Walker	PCT	R	PCT	R	
Heavy-Duty Mobility Equipment e.g. for bariatric patients	PCT	R	PCT	R	
Wheelchairs	NB: Wheelchairs and accessories provided by wheelchair services for permanent and substantial usage				
Push Wheelchairs, Standard Transit Chairs and Standard Wheelchair Cushion	CH		CH		
Bespoke wheelchairs / cushions and specialist seating	PCT	R	PCT	R	Local policies apply from Wheelchair Services

Ramps				
Ramps	CH		CH	Safety issue/DDA

Nursing Procedures				
Venepuncture				
Vacutainer Bottles for Blood Test	PCT		PCT	Via GP practice
Syringes and Needle	CH		PCT	
Catheterisation				
For Management of Catheterisation	CH		PCT	43.1
Catheters and Bags	PCT		PCT	Prescription
Routine Procedures				
Testing Urine	CH		PCT	Prescription
Aseptic Procedures				
Equipment used to support Aseptic technique e.g. probes, scissors, gloves etc	CH		PCT	
Dressings e.g. for procedures related to aseptic and clean dressings	PCT		PCT	Prescription via GP or Nurse Prescriber

Item of Equipment	Care Home Setting		Comments
	Nursing	Non-Nursing	

Patient Repositioning⁵			
Sliding Sheets	CH		CH
Transfer Boards	CH		CH
Ramps / passenger lifts	CH		CH
For Lifting and Manual Handling under Health & Safety At Work Act, e.g. Hoists, Slings, Transfer Boards, Glide Sheets, Turntables	CH		CH
Hoists: Ceiling Tracks	CH		CH
Hoists: Toileting	CH		CH

Non-standard hoists e.g. for bariatric patients	CH		PCT	R	
Bespoke Sling	PCT	R	PCT	R	
Standing Frames – for weight bearing to meet complex therapeutic need	CH		CH		

Prevention/Therapy and Management of Pressure Ulcers

Heel lift suspension boot	CH		CH		
Repose foot protector	CH		CH		
Leg trough	CH		CH		
Elbow lift suspension pad	CH		CH		
Dermal pads	CH		CH		
Gel pads	CH		CH		
Foam mattress/cushion – up to high risk	CH		CH		All foam mattresses must be a minimum of 5 inches depth. High specification foam mattress replacement is a minimum standard for all residents identified as vulnerable to pressure ulcer development.
Air Filled mattress/cushion – at risk	CH		PCT		
Alternating Air Overlay mattress and Cushion – high risk	CH		PCT		Alternating air overlay mattress must be placed on top of a base mattress with a minimum depth of 5 inches.
Dynamic Mattress/Cushion – very high risk	PCT	R	PCT	R	

Respiration/Routine Vital Sign Monitoring

For Maintenance of Respiration e.g. Suction Units	CH		PCT	R	
Oxygen Cylinders and Masks	PCT		PCT		NHS policy applies
Oxygen – Consumables	PCT		PCT		NHS policy applies
Simple Nebulisers	CH		PCT		Via Respiratory Team
Non-Standard and Complex Nebulisers (e.g. for ENT, CPAP BIPAP)	PCT		PCT		Via Specialist Team
Thermometer and sphygmomanometer	CH		PCT		Routine investigations carried out by PCT staff.
Backrests to aid respiration	CH		CH		

Sensory/Hearing			
Vibrating clocks	SS	SS	
Flashing Fire Alarms	CH	CH	Standard provision for registration
Flashing Door Bells	CH	CH	As above
Mini Comms	CH	CH	As above
Hearing Loops	SS	SS	To meet individual needs
Sensory/Visual			
Range of Canes	SS	SS	
Liquid level indicators	SS	SS	
Magnifiers, glasses	PCT	PCT	NHS policy applies / prescription
Toileting			
Fracture pan (bed-pan)	CH	CH	
Range of commodes: standard	CH	CH	
Toilet seats: standard raised 2", 4", 6"	CH	CH	
Urinals/bottles	CH	CH	
Urinals/bottles: non-return valves	CH	CH	
Continence products	PCT	PCT	PCT provide products to Residential Homes. PCT provides funding to Care Home with Nursing and home provides the appropriate products.
Non-Standard Commodes e.g. for people with complex treatment and health care needs i.e. bariatric	CH	PCT	R

General			
Hip Protector	CH	CH	
Head Protector	PCT	PCT	According to NHS policy

Equipment prescribed by authorised prescribers for urgent needs end of life care will be delivered by stores within 4 working hours or later as agreed.

Key

R – Subject to review

Care Home responsibility to provide

Social Services responsibility to provide

PCT – Health provider responsibility to provide i.e. PCT, initiating trust, FP10 etc

In the case of equipment being provided by the care home, the care home is responsible for:

- Ensuring all pressure relief equipment is examined at a minimum monthly (or in line with the review of individuals care plan) to ensure the pressure relief properties are still effective. This applies to all mattresses and cushions including static foam.

- All equipment provided by the home must be serviced and maintained in line with legal requirements and national standards.
- The home must ensure they have an infection control policy, which includes suggested decontamination methods for commonly used equipment, and details the cleaning and disinfection process to be used.

In the case of equipment being loaned to the care home, the home is responsible for:

- Identifying when equipment is no longer required
- Returning any equipment not needed promptly
- Notifying any changes in the client for whom the equipment has been loaned
- Equipment loaned will be for the sole use of the person whom it was prescribed for.
- If other people use the equipment and an incident occurs the NHS provider can not be held liable.
- The care home will meet the cost of all repairs arising from negligence, damage or inappropriate use and the cost of its replacement if it is lost.
- The PCT will periodically check that any equipment issued to named individuals remains in use and still required.

Please Note:

The allocation of responsibility for the provision of equipment for people in care homes will be reviewed when this contract term ends. All sections of equipment marked with 'R' on the above table will be subject to review.

The PCT envisages that in the future all beds and seats should have either castellated foam, visco (memory foam) or gel mattresses and cushions as standard provision in care homes, therefore as the home replaces the current provision, you are encouraged to replace seats and mattresses to this standard.

The PCT also envisages that Care Homes will be responsible for providing adjustable height beds in future. Electric profiling beds are recommended as standard provision in accordance with the needs of their Service User.

SCHEDULE 16 - TISSUE VIABILITY IN CARE HOMES

1. Assessment

1.1. If a Service User has a wound, a wound assessment must be completed by the home staff and must include:

- 1.1.1. Date of assessment
- 1.1.2. Date wound identified/developed
- 1.1.3. Photo of each wound
- 1.1.4. Measurement of each wound
- 1.1.5. Pressure ulcer grade if applicable
- 1.1.6. Site of wound
- 1.1.7. Description of tissue
- 1.1.8. Indication if wound is healing
- 1.1.9. Indication if infection is present
- 1.1.10. Body map, if more than one wound is present

2. This wound assessment must be evaluated at least weekly

- 2.1. Following the wound assessment, an appropriate treatment regime must be agreed and a wound treatment chart implemented, describing the wound dressings and the dressing process for each wound.
- 2.2. In addition to the above, each service user must have the appropriate documentation within the Care Plan, for each identified wound, repositioning plan, and skin inspection chart.
- 2.3. Each service user must have a pressure ulcer risk assessment documented and reviewed at least monthly.
- 2.4. If assessed as being at risk of developing a pressure ulcer, each service user will have a treatment plan within the Care Plan for the prevention of pressure ulcers, and provision of appropriate pressure relieving equipment.
- 2.5. Each service user must be assessed in line with the information contained prior to a referral to Tissue Viability Nurses.

3. Mattresses

- 3.1. It is the responsibility of the Provider to provide a range of mattresses to meet the service user's needs and in accordance with Schedule 15 - Equipment Provision in Care Homes. In addition:
 - 3.1.1. The minimum standard is a high specification foam mattress replacement for all service users identified as vulnerable to pressure ulcer development (NICE, 2005).
 - 3.1.2. All foam mattress replacements must be a minimum of 5 inches in depth.
 - 3.1.3. There should be no hollow core fibre overlays in use.
 - 3.1.4. No foam overlay mattresses should be used with service users identified as vulnerable to pressure ulcer development.

3.1.5. All alternating air overlay mattresses must be placed on top of a base mattress with a minimum depth of 5 inches.

3.2. Following a risk assessment for bed rails, extra high bed rails must be purchased for use with an alternating air overlay mattress (MHRA, 2006).

3.3. Any new alternating air overlay mattresses purchased must have an audible alarm system.

3.4. The NHS may provide an alternating mattress replacement system for service users who meet the criteria set out in Appendix I. A referral form should be completed and faxed to the Tissue Viability team (See Appendix IV).

3.5. It is the home's responsibility to meet the criteria set out in Appendix 3.

4. Bed frames

4.1. It is the home's responsibility to provide bed frames that meet the service user's needs and to ensure they are 'fit for purpose'.

4.2. Any newly purchased beds should be high/low or profiling as a minimum standard.

5. Seating

5.1. It is the home's responsibility to provide seating that meets the service user's needs and is fit for purpose.

5.2. If a service user requires specialist seating, a specialist seating assessment must be completed by an Occupational Therapist or a Physiotherapist and a referral to the Equipment Loans Service or NHS commissioners should be made.

5.3. The NHS recommends that any newly purchased seating should have built-in pressure relieving properties to all contact surfaces.

6. Cushions

6.1. It is the home's responsibility to provide pressure reducing cushions that meet the service user's needs and to ensure that they are fit for purpose.

6.2. Any service user identified as being vulnerable to pressure ulcer development should have (as a minimum) a castellated foam pressure reducing cushion.

6.3. Foam pressure reducing cushions with a depth of less than 3 inches must not be used for service users assessed as vulnerable to pressure ulcer development.

7. Targeted Pressure Reduction

7.1. It is the home's responsibility to provide targeted pressure reducing equipment that meets the service user's needs and to ensure that it is fit for purpose. This includes:

7.1.1. Heel lift suspension boots

7.1.2. Repose foot protectors

7.1.3. Leg troughs

7.1.4. Elbow lift suspension pads

7.1.5. Dermal pads

7.1.6. Gel pads

7.2. The following devices must not be used as pressure reducing equipment (NICE, 2005)

7.2.1. Sheepskins

7.2.2. Doughnut type devices

7.2.3. Water filled gloves

7.3. All of the above information must be viewed in conjunction with the Tissue Viability Website.

8. The Provider must ensure decontamination processes and infection control policies are implemented and utilised appropriately.

9. Tissue Viability Team

9.1. Referrals to the Tissue Viability team must only be made via a referral form (See Appendix 2).

9.2. Upon receipt of the referral the Tissue Viability Nurse (TVN) will contact the home and provide telephone advice. Each referral will be judged on an individual basis for appropriateness and need of a TVN assessment.

10. Audit

10.1. Each home must allow the Tissue Viability team access to complete a Tissue Viability audit on an annual basis. This will include access to all documentation, equipment and the right to speak to all service users and gain verbal consent for a skin inspection to take place.

11. Training

- 11.1. It is the Provider's responsibility to ensure that all staff are provided with appropriate training regarding pressure area care, upon induction and receive regular updates when required.
- 11.2. The Tissue Viability team will provide evidence based training for the qualified and unqualified staff working in homes where required.
- 11.3. It is the homes responsibility to contact the Tissue Viability team to book onto any training courses as required.

12. Link Nurses

- 12.1. Each home will be encouraged to allocate a link nurse specifically for Tissue Viability.
- 12.2. Each home will be encouraged to allow the link nurse to attend a quarterly meeting with the Tissue Viability team within the working hours of the individual nurse.
- 12.3. Tissue Viability will provide the link nurse with training and competency assessments to enhance their skills and knowledge.

Appendix I

Guidance for Equipment Selection

Please ensure a comprehensive programme of care has been put in place incorporating continence management and repositioning.

Guidelines for selecting:

A high specification foam mattress

To be provided by the home where any of the following applies:

1. The service user is assessed as being vulnerable to pressure ulcer development.
2. The skin integrity is intact.
3. The service user is able to move in bed independently or has a structured repositioning regime.
4. The service user spends less than 10 hours in bed in 24 hours.

An Alternating Air Overlay Mattress

To be purchased/rented by the home where any of the following applies:

1. A service user has been assessed as being at high risk of developing a pressure ulcer.
2. The service user spends more than 10 hours in bed in any 24 hour period.
3. There is difficulty repositioning the service user but a repositioning regime exists.
4. The service user has a history of pressure ulceration.
5. The service user has a grade 1 or grade 2 EPUAP pressure ulcer (not heels, targeted pressure reduction required).
6. The service user's skin integrity is deteriorating on a static foam mattress.

Please note: Identified risk is dependent on risk assessment using an identified risk calculator, holistic assessment and clinical judgement.

A Bi-Wave (Prevention/Treatment) Alternating Mattress Replacement System

The Service User must fulfil at least three of the criteria to qualify for an NHS funded system:

1. The service user has been assessed as being at very high risk of developing a pressure ulcer.
2. The service user spends more than 15 hours in bed on a regular basis.
3. There is difficulty repositioning the service user but a repositioning regime is in place.
4. The service user is deteriorating on an alternating air overlay mattress despite repositioning.
5. The physical condition of the service user is likely to deteriorate in the foreseeable future.
6. The service user has a history of pressure ulceration.
7. The service user has a grade 1 or grade 2 EPUAP pressure ulcer (not heels).
8. The service user has a grade 3 or grade 4 EPUAP pressure ulcer and consideration has to be given to comfort in relation to weight, pain or terminal illness (not heels).

A Trinova (Treatment) Alternating Mattress Replacement System

To be provided by the home where any of the following applies:

1. The service user has a grade 3 or grade 4 EPUAP pressure ulcer (not heels).
2. The service user is unable to be repositioned.
3. The service user spends more than 20 hours in bed.
4. The service user is deteriorating on a Bi-Wave alternating mattress replacement system despite repositioning.

Appendix 2

Tissue Viability for Nursing Homes Referral Form for Tissue Viability Assessment

Patients Name:	NHS Number:
Date of Birth:	GP:
Nursing Home:	Nursing Home Contact Number:
Home Address & Telephone Number: Postcode:	Reason for Referral:
Medical History:	Current Medications:
Current Treatment:	Current Equipment:
Type of Wound:	Date of Onset:
Other Professionals Involved:	Any other Relevant History:
Referrer: (Please Print Name)	Date of Referral:

Office use:

Date referral received:.....

Visit arranged Y

N

Date of review:.....

Appendix 3

Alternating Air Mattress Replacement Systems for Care Homes

Home Responsibility

1. Once the mattress replacement system has arrived at the home it becomes the responsibility of the home to use it in accordance with the instructions it has been given.
2. The systems should be maintained according to the manufacturers' guidelines.
3. Any user damage to the mattress replacement system other than reasonable wear and tear will be charged to the home.
4. It is the homes responsibility to 'step down' the mattress replacement system to an alternating air overlay system when the wound has healed. The mattress replacement system can be kept at the home for up to two weeks in case the alternating air overlay system is deemed not suitable.
5. Once the mattress replacement system is no longer required it is the nursing homes responsibility to inform any relevant persons to have the equipment collected.
6. It is the responsibility of the home to inform the Tissue Viability team once the system is no longer required.
7. The equipment provided must not to be used for any other service user.

Monitoring

1. The Tissue Viability team will maintain a database to monitor equipment usage.
2. The NHS will randomly select 4 homes each quarter to undertake an audit to monitor appropriate usage of equipment.
3. An annual summary of equipment usage will be prepared by the NHS.

Appendix 4

Alternating Air Mattress Replacement Systems for Homes

Referral Process.

1. If a service user is assessed as being high or very high risk of developing a pressure ulcer or has existing pressure damage the guidelines for appropriate equipment selection should be referred to.
2. If a service user fits the criteria for a foam mattress, the home has the responsibility to provide.
3. If a service user fits the criteria for an alternating air overlay mattress, the home has the responsibility to provide.
4. If a service user fits the criteria for an alternating mattress replacement system, they should be referred to a Community Health Care Co-ordinator, Discharge Liaison Nurse or Tissue Viability Nurse so an assessment can be completed.
5. A referral form must be completed by one of the above three professionals and faxed to the Tissue Viability team.
6. The referral form must be completed accurately as the Tissue Viability Nurse's decision will be based upon this information.
7. The referrer may be contacted to discuss the referral further.
8. Any decision will be made within 48hours. If approved the system will be ordered by the Tissue Viability Nurse and the referrer will be sent confirmation via email.
9. It is the referrers' responsibility to confirm the date of installation with the home.

Appendix 5 Referral Form for Mattress Replacement Systems; Nursing Homes Only

Patients Name:	DOB:	GP:
Proposed Discharge Date: Nursing Home Address:		Current Residence: Hospital: QEH <input type="checkbox"/> MHH <input type="checkbox"/> HEFT; GHH <input type="checkbox"/> Heartlands <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (please state): <input type="checkbox"/>
Telephone Number:		-----
Referrer: Email Address:	Contact Number:	Profession: CHCC <input type="checkbox"/> DLN <input type="checkbox"/> TVN <input type="checkbox"/> Other <input type="checkbox"/> -----
Diagnosis:	Pressure ulcers: Site(s) and Grade(s):	
Current Pressure Relieving Equipment:	How long does the patient spend in : Bed Chair	
	Is it possible to reposition the patient? Y <input type="checkbox"/> N <input type="checkbox"/>	
Equipment requested: Bi wave (Prevention/Treatment) <input type="checkbox"/> Trinova (Treatment) <input type="checkbox"/>	Any special considerations:	
Comments		
Fax to 0121 465 4777. Confirmation of installation date will be by email within 48hrs.		

Signature of referrer..... Date.....

Office use:

Discussed with referrer: Yes No

Appropriate referral: Yes No

Comments:

Mattress replacement to be ordered: Yes No Biwave Trinova

Agreement number.....

Installation date.....

Confirmation email sent: Yes No

SCHEDULE 17 – PALLIATIVE / END OF LIFE CARE IN CARE HOMES AND OTHER CARE SERVICES

End of Life Care in Care Services will be provided in line with the DH End of Life Care Quality Markers. Care Services will demonstrate the following:

Link with GP Palliative Care Register

Link with the local End of Life Care Pathway.

Summary of key issues:

1. They have an action plan in place for End of Life Care. The Care Service should have a strategic approach / protocol / policy / facilities for services provided in the dying phase.
2. That they have mechanisms in place to discuss, record and communicate the wishes and preferences of Service Users regarding their End of Life Care.
3. That Service User's needs for End of Life Care are assessed and reviewed on an ongoing basis
4. That Service Users who are dying are entered onto a health care pathway and the Care Service can demonstrate joint working with health End of Life Care Services
5. That the quality of End of Life Care provided by the Care Service is audited and reviewed
6. That they have processes in place to identify the training needs of all staff that takes into account the four common requirements for workforce development (communication skills, assessment and care planning, advance care planning and symptom management).
7. That they review the appropriateness of all moves of the Service User between the Care Service and other services when approaching the end of their life (unnecessary admissions to hospital, prolonged stay, choices)

Key Issues in Detail:

1. The Care Service has an End of Life Policy and there is an action plan in place for End of Life Care
 - The Care Service uses a validated tool or combination of tools to guide and inform the provision of Palliative / End of Life Care for Service Users for example Preferred Priorities of Care (PPC), Supportive Care Pathway (SCP) and the Liverpool Care Pathway (LCP).
 - The Bham and Solihull NHS Cluster is adopting the Gold Standard Framework as the recommended approach. A health professional should be brought in to initiate and complete the Gold Standard Framework pathway paperwork.
 - The quality of End of Life Care provided by the Care Service is regularly audited and reviewed.
2. Mechanisms are in place to discuss, record and communicate the wishes and preferences of those approaching the end of life.
 - There is evidence of open and sensitive discussion with the Service Users and their significant other / relative's thoughts and wishes about End of Life Care.
 - Individual Service User's Palliative / End of Life Care needs are identified and choices will be recorded and communicated to the Service User and relatives.
 - Ensure each Service User has their holistic (physical, psychological, social, cultural and spiritual) needs, preferences and symptoms assessed, plan of care discussed, recorded, care implemented, evaluated and reviewed using appropriate assessment tools.

- Establish and record the existence of Advanced Directives, Enduring Power of Attorney, next of kin and DNA/CPR decisions.
 - Contact details for the next of kin / preferred contact are confirmed and updated, indicating a clear contact list over any 24 hour period.
 - The Service User will be included on the GP's Palliative Care / Gold Standard Framework register
 - Service User needs for End of Life Care are assessed and reviewed on an ongoing basis, but at least monthly.
 - Relatives are offered the opportunity and support to be involved in care and guided about open visiting where the Service User is in a care home.
 - Discussions are documented and incorporated into a person centred care plan.
 - In order to maintain continuity of care, systems should be developed to transfer information to any Out of Hours Provider (OOH). Care staff to understand the rationale and procedure for notifying any Out of Hours Provider with regard to any anticipated need or deterioration of a Service User.
3. The Care Service will ensure appropriate and effective symptom management is provided in line with the approved joint formularies.
- Symptoms assessed should include pain, nausea / vomiting, agitation, swallowing, breathing, bowel management, excess secretions as well as psychological symptoms. Using validated assessment tools, registered nurses and care staff should have a clear understanding of their role and responsibilities in the provision of palliative and End of Life Care.
 - The Care Service should have tools to identify non verbal signs of distress
 - Registered nurses and care staff should acknowledge their limitations and recognise when, who and how to refer a Service User to a specialist palliative care practitioner.
 - There is documented evidence of involvement from different health professionals as required.
 - Ensure PRN (take as required) / rescue doses of medication are prescribed to manage breakthrough pain where required.
 - There should be discussion with the GP, the Service User and relatives to identify if anticipatory medication can be prescribed, if appropriate, should the Service User's condition deteriorate.
4. The Care Service will have processes in place to identify the training needs of all staff that takes into account the four common requirements for workforce development (communication skills, assessment and care planning, advance care planning and symptom management).
- The Care Service has a programme for staff training, development and continued learning needs around palliative and End of Life Care.
 - Care Service staff will have core knowledge and skills regarding Palliative / End of Life Care.
 - The Manager of the Care Service should support individual staff to identify learning/training need .
 - Care Service should have access to a rolling programme of Palliative / End of Life Care education and training.
 - There should be formal processes in place to monitor practice.

5. The Care Service will be proactive in the recognition of the dying phase.
 - Multi Disciplinary Team (MDT) review of Service Users. Awareness and documentation that Service Users is in terminal phase and for comfort measures will apply rather than active intervention.
 - Privacy and dignity of Service Users to be maintained at all times including after death.
 - Service Users who are dying are offered entry onto an End of Life Care pathway
 - More frequent reassessment of the Service User's holistic needs, preferences and symptoms will be recorded, discussed, reviewed and acted upon appropriately. The Care Service needs to be able to respond to change of wishes at short notice.
 - Ensure medication is reviewed in relation to symptom control, ensuring appropriate medications prescribed and available for use.
 - Up to date information to be sent to OOH provider, as changes occur if appropriate.
 - Facilities to allow relatives / significant others to participate in provision of care provided in care homes and allowed to stay if required. There is no obligation to provide refreshments free of charge or facilities for more than one person.
 - Access to pre bereavement support as required in house or refer to specialist provider.

6. Processes are in place to review any moves of Service Users to and from services in their last year of life
 - With the aim of reducing unnecessary hospital admissions, staff should liaise with MDT, Service User, carers and relatives to regularly review Advanced Care Plan and Do Not Attempt Cardio Pulmonary Resuscitation status.
 - Care Services are under no obligation to accept a new Service User in the dying phase, until GP cover is agreed and in place.

7. The Care Service will offer support to staff, carers and other Service User following bereavement.
 - To ensure appropriate psychological, religious or spiritual support when required for families and staff members and other residents where the individual is living in a care home
 - Reflection following the death of the Service User should be encouraged and learning outcomes identified.
 - Acknowledgement of individual limitations with regard to offering bereavement support and signposting to appropriate specialist services as required such as Cruse Bereavement Services.

8. Payments to Providers following the death of a Service User will be made in accordance with schedule 7 (finance, invoicing and payments)

SCHEDULE 18 - NUTRITION AND DIETETICS IN CARE HOMES WITH NURSING: IDENTIFYING AND MANAGING MALNUTRITION AND DEHYDRATION

NUTRITION AND DIETETICS

Introduction

The Nutrition Support Team, part of the city-wide Birmingham Community Nutrition and Dietetic Service (BCNDS), provides services to Service Users in Care Homes with Nursing throughout Birmingham, providing they have a Birmingham GP. The team is made up of registered Dietitians, Nutrition Nurses and Dietetic Assistant staff and is supported by their own administration staff.

The main emphasis of this team is to support Care Home staff through training and advice allowing them to screen, monitor and care for Service User's nutritional needs in an effective way. Service Users within Care Home with specialist nutritional needs e.g. Enteral feeding, specialised diets or those Service Users requiring a modified texture will be seen initially on a one to one basis by our team. Follow up care will be at the discretion of the dietitian/ nurse however enterally fed patients will be reviewed on a 3 to 6 month basis as recommended by NICE (CG32 NICE 2006).

Screening

The Malnutrition Advisory Group of BAPEN recommends all Service Users are screened on admission to a care environment to assess the risk or presence of malnutrition. Screening will need to be repeated at specified intervals depending on the score obtained.

- BCNDS recommend the use of a nationally validated tool such as the Malnutrition Universal Screening Tool (MUST), (BAPEN 2003) however we recognise the need for local tools in some instances.
- Where nutritional screening indicates the need for intervention targets should be set including initiating first line dietary advice to include food fortification if necessary. Intake and weight should be monitored and reviewed frequently.

Training

BCNDS recommend all staff attend a MUST training session which will cover the identification of malnutrition and the initiation of First Line (High Protein/ High Calorie advice). It is recommended that an update session is completed at least every two years.

At least two individuals from the Care Home should be identified as Nutrition Champions or link nurses to act as a link between the Nutrition Support Team and the home cascading training and updates as appropriate.

Ongoing training modules should be accessed off site via the nutrition and dietetic department through their Nutrition Essentials Training (Appendix 3)

Care Planning

Nutrition should form part of the Care Plan of all Service Users it should include the following:

1. Nutrition Screening Tool score, action plan and reassessment date
2. Need for a special/fortified or modified consistency diet.
3. Food Preferences or restrictions due to cultural or religious beliefs.
4. Supplement Prescription
5. Weight History to include either BMI or mid arm circumference/ ulna length
6. Food/Fluid chart if required for monitoring

The specific dietary needs of the Service User should be reviewed by care staff and discussed with catering staff, in accordance with the Care Plan and should be reviewed on a regular basis or if a clinical change occurs.

Monitoring Food Intake

Food intake should be monitored and recorded on a daily basis. A poor intake for 5 days or more should be investigated.

Monitoring Fluid Intake

Care staff should be aware of the risk of dehydration particularly those with underlying conditions such as swallowing problems, lack of coordination and vomiting.

Fluid intake should be monitored in all Service Users who are not drinking freely and should aim for a minimum of 7 cups (1500 mls) per day.

Dehydration may exacerbate problems such as constipation, urinary tract infections and pressure sores.

Provision of Food

The menu options should be based on nutritional guidelines

The Care Home is responsible for providing specific therapeutic diets including modified textures advised by dietetic staff or speech and language therapists

Pureed foods should be fortified with milk, milk powder and cream during preparation.

Service Users should be provided with a culturally/religiously acceptable meal. If this is not possible to prepare these on site, suitable meals may be externally sourced.

Religious festivals should be accommodated by the Care Home (if medically appropriate).

Service Users should be given sufficient time to eat and protected mealtimes should be encouraged.

Independent eating should be encouraged for as long as possible with provision of adaptive aids if needed. Staff should offer assistance with eating and drinking where necessary.

Food provision should be reviewed annually with catering staff, care staff, Service Users and or/next of kin.

Supplements

It is the Care Homes' responsibility to ensure they have sufficient stocks of prescribed nutritional supplements for Service Users.

Before giving the supplement please check that it is in date and is the one indicated on the prescription chart. The supplement should be named and dated on opening. Supplements should be consumed or discarded four hours after opening.

Artificial Nutrition – Equipment

All equipment should be used in accordance with schedule x – equipment

If a Nasogastric Tube is used for feeding then:

- Details of the type of tube being used and insertion date should be recorded following placement
- The limiting mark at the nostril should also be recorded.
- pH should be checked using pH paper/indicator strips before the tube is used for feed, medication or fluid. pH should be 5.5 or below (NPSA 2004)
- Nasal erosion, fixation and condition of the tube checked daily.

If a Percutaneous Endoscopic Gastrostomy (PEG) is used for feeding then:

- Details of the type of tube being used/ insertion date should be recorded
- Advance and Rotate the tube daily
- Ensure fixation disc is no more that 0.5 cm away from the skin
- Clean stoma site daily

If a Balloon Gastrostomy Tube is used for feeding then:

- Detail type of tube, the insertion date and balloon volume should be recorded
- Check the balloon volume weekly
- Check tube position with pH paper/indicator sticks on insertion or if any concerns regarding the position of tube

Artificial Nutrition – Feeds

Care Homes have the choice to obtain feed on prescription either via Homeward part of Nutricia or from a local chemist.

It is the Care Homes responsibility to ensure they have sufficient stocks of feed for each Service User and consideration should be given to bank holidays and weekends when the provision of feed will be more difficult.

Details of the feed should be checked against prescription and documented on the appropriate chart.

Service Users on an enteral feed should have the following monitored and recorded in the care plan:

- Volume, rate and type of feed and water flushes daily
- Fluid balance charts and bowel movements chart.

Training on care of Service Users with enteral feeding tubes and equipment can be accessed via the nutrition and dietetic department or via the Nutricia, the PCT contracted Nutrition Company.

Audit

Compliance with these recommended quality standards may be assessed by quarterly audit of the food and fluid charts, menus and enteral feeding charts together with the Service User's medical records.

Additional Information

Further information and details of how to refer to the BCNDS' Nutrition Support Team are available from our web site www.dietetics.bham.nhs.uk

The Guidelines for the Treatment of Under-nutrition in the Community 2010– developed by BCNDS' Nutrition Support Team.

SCHEDULE 19 – TRAINING REQUIREMENTS FOR CARE HOMES WITH NURSING

1. PURPOSE

1.1 Aims

- 1.1.1 To provide an accurate profile of the training required and undertaken within nursing home settings
- 1.1.2 To promote the standard of care delivery within care homes with nursing.
- 1.1.3 To provide standard recording, reporting and management of training needs.

1.2 Evidence Base

The Nursing and Midwifery Council (NMC) is charged with ‘safeguarding the health and well being of persons using or needing the service of registrants’ it does this by establishing from time to time standards of education, training, conduct and performance for nurses and midwives and to ensure the maintenance of those standards (NMC Order 2001)

The NMC Code state that each individual must ensure that their skills and knowledge are kept up to date and must have the knowledge and skills for safe and effective practice when working without direct supervision. Each individual must recognise and work within the limits of their competence and must take part in appropriate learning and practice that maintain and develop competency and performance.

It is the responsibility of the Birmingham Primary Care Trusts to identify, commission and contract services required to meet the needs of people who are registered with a Birmingham Primary Care Trust GP. This is in line with the Department of Health “National Framework for NHS Continuing Healthcare and Funded Nursing Care” (published October 2009). Care Homes with Nursing who are contracted to provide a service should have suitably trained staff to undertake the care needs of their residents.

2. OVERVIEW

Care Homes with Nursing will put in place robust systems for identifying and sourcing training in order to provide person centred care to their resident population. This will include the recording of training received by each member of staff relevant to their specific roles and frequency of training updates.

2.1 Objectives

- To ensure appropriate and relevant training for all staff.
- To ensure training outcomes are implemented across the home and incorporated into the Service User’s Care Plan.
- To ensure a training programme is implemented in a systematic approach to safeguard the delivery of care to Service User.
- To develop and implement an appropriate training schedule to meet the needs of the Service and Service Users.
- To maintain records of training delivered, outcomes and staff competence within a training matrix.

2.2 Training schedules for all staff at appropriate level and as appropriate:

Basic Life Support
Catheterisation
Continence care
Diabetes
DoLS and Mental Capacity
End of Life
Falls
Fire safety
Food hygiene
Health and Safety
Infection control
Manual Handling
Medicine administration
Medicine management
Nutrition
Phlebotomy
Safeguarding Adults
Tissue Viability
Person centered care including dignity and respect

The above list is not exhaustive; training will be dependent upon the needs of the Service User.

2.3 Expected Outcomes

Staff will have the necessary skills to provide quality care for their client group of residents.
Reduction in the number of ambulance call outs
95% attendance of staff at mandatory training
Established links with GP's/IMDT 's