Healthier
Lancashire &
South Cumbria

Residential and Nursing Care Specification

1. INTRODUCTION

1.1. This document sets out the care specification and standards, which apply to the Lancashire County Council contract for the Provision of Older Adults Residential & Nursing Care Services.

1.2. The Commissioners are committed to the development of a range of care services in which the Local Authority and Clinical Commissioning Groups and independent providers work in a spirit of consultation, co-operation and partnership to ensure that appropriate services are available to meet the needs of Lancashire people.

1.3. This document sets out agreed Service User focused outcomes in line with the Care Quality Commission's The Fundamental Standards and in the context of other legal requirements and key national best practice guidance.

2. LEGAL REQUIREMENTS AND CONTEXT

2.1. The Agreement places an obligation on the Provider to comply with all legislation and regulations relevant to the provision of the services.

2.2. This Specification reflects how the Provider supports the Commissioners in meeting the requirements of the Care Act 2014 for the care and support needs of people in a care home to ensure that services:

- provide quality and choice;
- are sustainable;
- innovate to meet the diversity of outcomes for people; and
- deliver cost-effective outcomes.

2.3. The Person-Centred Outcomes in the specification relate to how Service Users' wellbeing can be assured whilst supporting person-centred care and support. Wellbeing is defined as follows in line with Care Act guidance:

- personal dignity (including the way people are treated and helped)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control over day to day life (including making choices about the way care and support is provided)
- participation in work, education, training and recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation

- the individual’s contribution to society

2.4 Collaboration between the Commissioner and Provider is important. This includes the workforce and people with care and support needs, carers and families, facilitating the Commissioner in meeting Care Act requirements.

2.5. The Providers’ adult safeguarding policies and procedures will reflect the statutory guidance and the Lancashire Safeguarding Adults policy with the clear aim to support the reduction or removal of safeguarding risks as well as to secure any support to protect the adult and, where necessary, to help the adult recover and develop resilience. A partnership approach will encourage proportionate responses and improve the involvement of Service Users themselves in the decision-making and involvement in prevention and developing resilience for themselves.

2.6. The Provider shall be registered with the Care Quality Commission (CQC) in accordance with the Health and Social Care Act 2008 and comply with all related requirements. The service offered to the Commissioner shall not exceed the “Type of Service” and “Specialism/Services” registered.

2.7. National Performance Indicators that apply relate to the Department of Health Adult Social Care Outcomes Framework (ASCOF) as follows:
Service User views on the service relating to: -

- how much control they have over their daily life
- how they feel about themselves because of the way they are treated and helped
- how clean and presentable they feel
- the food and drink they want and when they want it
- feeling safe
- how much social contact they have
- spending time together doing the things they value and enjoy

2.8. Active engagement and openness between Commissioners and Providers is also important for meeting duties relating to potential “Business Failure” (meaning an event such as the appointment of an administrator, the appointment of a receiver or an administrative receiver) or “Service Interruption” to the whole of the regulated activity, meaning an imminent jeopardy and there is no likelihood of returning to a “business as usual” situation in the immediate future, leading to the need for joint action by the Commissioner and the Provider. In these situations, the Provider and all parties will cooperate fully as identified by the Commissioner.

2.9. The Social Care Institute of Excellence (SCIE) Think Local Act Personal partnership provides guidance for social care and health.

2.10. The National Institute for Health and Care Excellence (NICE) provides guidance, advice and information services for health, public health and social care professionals.

2.11 The Code of Conduct for healthcare support workers and adult social care workers provides guidance for the standards of conduct expected of workers.

2.12. Public Health England provides guidance on matters such as infection control, Resuscitation Council UK and Royal Pharmaceutical Society Guidelines.

2.13. From time to time, the Commissioner may seek the Provider's agreement to comply with the standards and recommendations issued by any relevant professional or by the National Institute for Health and Social Care Excellence (or any other equivalent body).

2.14. The Provider will comply with General Data Protection Regulations 2016 (GDPR) shown in Appendix 1

2.15. Whilst the Commissioner aims to refer Providers to good practice guidance in this specification, the Provider is expected to know and keep up to date with best practice.

3. OUTCOME BASED SERVICES

3.1. The aim of an outcome-based approach is to shift the focus from tasks and processes to the impacts of these on Service Users. Success by achievement of individual outcomes will be evidenced primarily but not exclusively by the satisfaction levels of Service Users and their carers and their experiences in the service and the impact on their wellbeing.

3.2. Achievement of the individual outcomes identified in the Service User's care and support plan shall ensure that Service Users: -

- are valued – involved, more in control, listened to, told what is happening, given choices, at the centre of what is happening to them
- retain their strengths and independence – ensuring that an individual's quality of life is maintained by keeping active and alert, maintaining mobility/physical health, maintaining hygiene, maintaining social contact and keeping safe and secure
- are supported through change - e.g. post-operatively, at the end of their lives and in situations where poor care or self-care has resulted in a reduction in their independence
- are safe – services are well managed and provided by staff who work competently with Service Users because they are appropriately trained and supervised to take person centred approaches.

4. SERVICE STANDARDS AND MONITORING

4.1. The Council has responsibilities under the Care Act 2014 to ensure that the services delivered to people in a care home:

- provide quality and choice;
- are sustainable;
- innovate to meet the diversity of outcomes for people; and
- deliver cost-effective outcomes.

4.2. The Provider will supply information on request so that the Commissioner can inform its commissioning activities and work with the sector to achieve these outcomes.

4.3. The following **Service Standards** have been developed and will be used as the basis for monitoring the Service provided:

- 4.3.1. The Person-Centred Outcomes set out in Section 5 of this Specification;
- 4.3.2. The Framework for Enhanced Health in Care Homes;

- 4.3.3. Lancashire Safeguarding Adults Board; and
- 4.3.4. Any other quality requirements set by the Council, the CCG or any other relevant professional or regulatory body.

4.4. The Provider is required to demonstrate that the Service Standards are being achieved. The Commissioner will seek evidence of this via a number of methods, including the Contract and Quality Monitoring tool and quality assurance visits.

4.5. There is an expectation that the Provider will take into account other good practice standards and guidance not included in the Service Standards and will strive for continuous improvement of the Service.

4.6. Where the Provider is delivering care to Service Users under Dementia banding the Provider will work towards nationally recognised good practice standards such as King's College, Stirling University or equivalent.

4.7. The Provider will fully participate in and co-operate with the Council's multi-agency quality, performance and improvement planning (QPIP) process, this may include; attending meetings, providing information, production and implementation of a service improvement action plan and facilitating service reviews with the multi-agency quality improvement team. The process may change from time to time, guidance on the current process is shown at Appendix 2.

4.8. The Provider will complete e-forms upon request and submit electronically to the Commissioner via the contract and quality monitoring system.

4.9. The Provider will supply vacancy information to the Commissioner upon request in the format requested by the Commissioner.

4.10. The Provider will share the results, action planning and improvements made through internal quality monitoring processes including those detailed at Outcome 29: Quality Assurance.

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5.1. PERSON CENTRED OUTCOME 1

Provider Service Information
Service Users have the information they need to exercise informed choice about where to live and have the opportunity to visit and assess the quality, facilities and suitability of the home prior to admission.

5.1.1. An introductory visit for individuals, their family or friends shall be facilitated by the

Provider upon request.

5.1.2. Where a period of short-term care has been requested by the Commissioner, the Provider will assess suitability and negotiate a placement.

5.1.3. Service Users will have private single accommodation (unless shared accommodation is requested by choice) which they call their own to use as and when they wish. Service Users are offered a reasonable choice about the nature of the room which may include personalisation and the ability to lock their room, in line with Mental Capacity Act.

5.1.4. Service Users will be encouraged to bring personal possessions into the care home, including small items of furniture where practical. Arrangements will be put in place by the Provider for the recording of Service User's property and secure storage for valuables, and the Service User and/or representative is informed of any items unable to be stored dependent on the Provider's level of insurance cover.

5.1.5. The Provider shall produce a Service Users Guide which will state what is available within the service to assist people in deciding if the care home is right for them (e.g. indoor and outdoor facilities, social and community activities, cultural aspects, opportunities for education or work, recreation and leisure, IT and electronic communications). The Service User Guide will state how the Provider intends to meet specific needs, including aids and adaptation, what Service Users can expect by way of quality and how the Provider can show they are achieving this. Details of any additional services and costs not covered by Commissioner fees should also be clearly communicated with the Service User through the Provider's procedures.

5.1.6. This Specification and attached Contract and takes precedence over the home's own Contract. The Provider's own contract should be in line with the attached Contract and Specification.

5.2. **PERSON CENTRED OUTCOME 2**

Pre-admission Assessment/Needs Assessment
Service Users are only admitted on the basis that the home has carried out a comprehensive pre-admission assessment in order to demonstrate that they can meet their assessed and ongoing needs.

5.2.1. New Service Users, including those receiving short periods of respite, will be admitted only based on a full and holistic assessment undertaken by a competent person to satisfy themselves that the service can meet the needs and wellbeing outcomes relating to the level of care they require. Such assessments where possible should involve the prospective Service User, his/her representatives (if any) and relevant professionals.

5.2.2. Following admission, the Provider will build on the assessment referred to in 5.2.1 to develop a personalised care and support plan, which determines the Service User's self-care and includes functional abilities, physical, emotional, social, mental health and spiritual needs.

5.2.3. Where, during the period of stay a significant change in the level of need or service arises for an individual Service User, the Provider shall review and update relevant care plans, risk assessments and dependency levels. If the change in level of need impacts on service demand the Provider shall also inform the Commissioners within 7 days. A re-

assessment of the individual's needs shall then be undertaken by the Adult Social Care Teams and/or relevant Health Professional with timescales explained at the time the referral is accepted

5.2.4. Where an admission has been agreed by the Provider as an emergency, the full assessment and interim documentation will be completed within 48 hours of the admission.

5.2.5. Any additional resources needed to meet a Service User's needs will be recorded and progressed, for example, bespoke equipment or referrals to Health Professionals.

5.2.6. Where admissions are funded by the Commissioner, the Provider's assessments will be based on the Commissioner's assessments and care and support plans. If adequate information is not provided by Commissioners, the Provider will notify the Commissioner at the earliest opportunity.

5.2.7. Any requirement for Deprivation of Liberty Safeguards will be identified and referred to the Commissioner. The Provider is responsible to undertake the request for authorisation and the Provider will, where possible, apply for authorisation in advance of the admission. Applications are to be sent securely by email to the Local Authority's designated inbox email address: csc.acscustomerservices@lancashire.gov.uk as amended from time to time.

5.2.8. It is the Provider's responsibility to review Deprivation of Liberty Safeguard applications regularly and inform of any changes to circumstances which may affect the application or its urgency. Additionally, it is the Provider's responsibility to follow up outstanding applications and document accordingly.

5.2.9. The Provider shall record what accommodation is accepted by the Service User and any change must be agreed by the Service User and/or their representative.

5.2.10. The Provider will confirm prior to admission with Commissioners, Service Users, or their representatives, their fees and any additional costs or supplementary fees on top of the Commissioner's agreed rates. Documentary evidence of funding arrangements and agreements will be kept for review as required.

5.2.11 The Provider will confirm prior to admission with self-funding service users the possibility that a top-up will be applied if their savings falls below the threshold and a commissioning organisation takes on the funding responsibility.

5.2.12. The Provider shall have a register of all Service Users within the home including room numbers, funding authority, next of kin and General Practitioner details. Such information must be kept up to date and be accessible upon request by the Commissioner if this is required.

5.3. **PERSON CENTRED OUTCOME 3**

Care and Support Planning/Person Centred Care and Record Keeping
Service Users' ongoing health and social care needs are set out in individual person-centred care and support plans. Service Users' rights and best interests are safeguarded by the Provider's record keeping policies and procedures.

5.3.1. Following a comprehensive assessment, individual risk assessments will be undertaken, and person-centred care and support plan produced for all identified and

potential needs, promoting self-care and independence. A Service User who has the capacity to decide may not wish to eliminate risk, so risk management will be proportionate and a reasonable response to a risk which doesn't interfere with the Service User's desire to live the quality of life they wish.

5.3.2. Care documentation will be clear, legible and up to date. Where possible, support plans will not be hand-written, they will be in an appropriate format and of a length that staff are able to read and process the information. Care and support plans will be provided to the Commissioner on reasonable request.

5.3.3. Care documentation will follow the process of assessment, planning, implementation and evaluation and provide clear, concise and directive information that reflects the care required to meet the Service User's individual needs. Care and support plans shall include goals for independence and maintaining Service Users' abilities. Care and support plans and risk assessments will be reviewed as a minimum on a monthly basis or as and when the Service User's needs change.

5.3.4. All nursing documentation will be concise and accurate and will meet Nursing Midwifery Council Guidelines for Record and Record Keeping.

5.3.5. All records, including care records, daily records and charts must be legible to the reader, made at time of care delivery, or as soon as possible within reason, and in chronological order.

5.3.6. All documentation must reflect good practice guidance and meet legal requirements. It should also include relevant evidence-based nursing knowledge and current clinical guidelines both nationally and locally where appropriate to Service User needs.

5.3.7. Service Users and/or their representatives, including advocacy support, must be involved in the production of care and support plans and invited to attend care review meetings. Care and support plans will explicitly identify whether the Service User has consented to the plan. Where the Service User is unable to consent to the plan, the Provider will demonstrate they have followed the principles of the Mental Capacity Act, with documented evidence to demonstrate decision specific mental capacity assessment and how a best interest decision was made.

5.3.8. All Service User records will be stored in a secure place and will be available to appropriate staff. Records will be up to date, adhere to professional record keeping standards and be constructed, maintained and used in accordance with GDPR, the Data Protection Act 1998 and other statutory requirements. The Provider will describe in their Privacy notice what data they hold and how Service Users can have access to their records and information held about them by the Provider.

5.3.9. The Provider will undertake monthly audits of care and support planning and record keeping in order to demonstrate the accuracy, quality and consistency of information, measure the outcomes of care and ensure that risks to Service Users are minimised. Where actions have been identified through audit, the Provider will record and demonstrate that appropriate action has been taken including lessons learnt.

5.3.10. The Provider will ensure there is provision for a range of equipment necessary to meet Service User assessed needs and shall allow for variations in height, weight and size of Service Users. Risk assessments will be completed by a competent individual and, where bespoke equipment is needed, implementation will include a demonstration of the use of equipment, reducing risks as far as possible. Service Users will be included in the assessment, where practicable, to support understanding of how and why equipment is

used. Care will be taken to ensure a Service User’s privacy and dignity is maintained.

5.4. **PERSON CENTRED OUTCOME 4**

Meeting Needs and Outcomes/Continual Evaluation/Review
Service Users and their representatives know that the home they enter will endeavour to meet and continue to meet their needs and agreed outcomes.

5.4.1. The Provider will be able to demonstrate the ability to manage and respond to the assessed needs and outcomes of Service Users living in the home to ensure they receive the appropriate care, support and treatment in a timely manner.

5.4.2. Documentation and measurable outcomes will be maintained to clearly evidence the continual evaluation and review of Service Users’ needs.

5.4.3. Where evaluation and review indicate a change in the Service User's health and/or Social Care needs, the Provider shall make referrals through appropriate pathways to Health and/or Social Care Professionals for assessment. The Provider will document details of referrals, advice and/or recommendations made within the Service User's care records and relevant care and support plans are updated accordingly.

5.4.4. The Provider will ensure that staff individually and collectively have the skills, experience and qualifications to deliver the services and care which the home reports it will provide.

5.4.5. Specialised and appropriate services, including equipment will be offered and provided where assessed as needed. Where Service Users refuse equipment, the Provider will follow the principles of the Mental Capacity Act and retain evidence of appropriate assessments.

5.5. **PERSON CENTRED OUTCOME 5**

Short-term Care
Service Users receiving short-term care are supported to meet their identified outcomes and are supported to move on to alternative services at the end of the agreed placement period

5.5.1 Short-term care arrangements may be requested by the Commissioner in a number of circumstances, including, but not limited to:

a) As time-limited alternative whilst a longer-term care package is sought to meet the Service User’s needs;

b) Where the Service User requires a more in depth and on-going assessment of their circumstances or the agreement of their assessment by the Commissioner. Reasons may include:-

- Need for long term residential or nursing home care;
- Assessment of mental capacity for specific decisions related to their care;
- Resolution of family issues; or

- Safeguarding concerns surrounding the Service User's departure.

c) Where a Service User is admitted for a prescribed period of rehabilitation and/or therapy, the Service User may receive support from the NHS including occupational therapy and physiotherapy and other Health and Social Care professionals as appropriate to meet agreed outcomes.

d) In order to provide respite, for a prescribed period of time, for the Service User or their Carers.

5.5.2 It should be recognised by the Provider that short-term care in a care home can be a particularly difficult time for Service User and they will require extra support and reassurance during this period of great change. Providers should ensure that Service Users are kept fully informed at all times.

5.5.3 The Provider shall comply with this specification in the same manner as a long-term placement and shall meet any specifically identified outcomes such as those included in this clause.

5.5.4 Particular consideration should be given to Service Users with dementia care needs having short-term care or placements, which should be seen as an opportunity to spend time with people who will be interested in them as individuals and provide stimulating opportunities to try new things and make new memories where possible.

Short-term care for prescribed periods (also known as respite care)

5.5.5 Short-term placements should be approached in a way to support Service Users, families and carers in maintaining important relationships, maintaining and developing new skills, and should underpin and sustain the overall wellbeing of both individuals and families. Care and support should be flexible and individualised.

5.5.6 Where placements are planned in advance Service Users and their carers and families should be given the opportunity to talk about their expectations and individual outcomes so that the benefits of a short stay in the care home are maximised.

5.5.7 At the end of a short-term placement, the Provider shall support both the Service User and the Commissioner to manage a smooth transition to the next service or location. Any relevant care planning information will be shared on request with the Commissioner and any alternative care provider identified to support the Service User.

Short-term care for prescribed periods of rehabilitation and/or therapy

5.5.8 The Provider will co-operate and work alongside with rehabilitation and therapy services being delivered at the care home. Service Users care and support plans will adequately reflect the programme of rehabilitation and therapy or the requirements for achieving independence outcomes with clearly evidenced continual evaluation and review. It is expected that care and support plans will be reviewed on a more frequent basis appropriate to the type of stay and identified care needs and outcomes.

5.5.9 The Provider will ensure that staff individually and collectively have the skills, experience and qualifications to meet the identified outcomes and support identified needs.

5.6. **PERSON CENTRED OUTCOME 6**

Provision of and Access to Health and Social Care
Service Users receive appropriate evidence-based health and social care and have access to community services and specialist input to meet their assessed needs and maximise their health, independence and wellbeing.

5.6.1. Service User's health, independence and wellbeing will be promoted, monitored and maintained and referrals will be provided in a timely manner to relevant primary care and specialist health and social care services to meet assessed individual need.

5.6.2. Service User's physical, psychological and mental health will be proactively monitored, and early preventative and restorative care provided or arranged in order to improve health, promote independence and wellbeing and maintain their quality of life including: -

- Tissue viability and the management of wounds, as appropriate
- Continence management including the management of urinary catheters and stoma care
- The management of malignant and long-term conditions including but not limited to, Ischaemic Heart Disease, Stroke/TIA's, Diabetes, Chronic Airways Disease and Asthma, COPD, Parkinson's Disease and Multiple Sclerosis
- Health promotion, screening and preventative care
- Infection prevention and control
- Maintenance of mobility, functional ability and falls prevention
- Pain management
- End of life care
- Nutritional screening and support including the management of Service Users who suffer with dysphagia or require PEG feeding
- Oral health care including preventative care where the Service User needs carer support and access to appropriate dental services.

5.6.3. The Provider will provide care and support to Service Users to manage multiple long-term conditions in line with NICE guidance.

5.6.4. Service Users and/or their representatives are involved in decision making around care and health intervention.

5.6.5. The Provider will cooperate and implement reasonable recommendations made by relevant health and social care professionals.

5.6.6. Service Users shall have access to specialist health and social care aids and equipment according to assessed need and the Provider shall ensure staff are trained and assessed as competent in the safe usage of this equipment. The Provider shall ensure that they adhere to the requirements of the Commissioner's equipment policy.

5.6.7. The Provider will facilitate Service Users to have regular health checks including specialist and medical reviews of their health and medication and proactive screening and management of chronic disease processes.

5.6.8. The Provider will facilitate where appropriate access to digital systems, assistive technologies/ telehealth equipment in order to improve the functional ability of Service Users

with long term conditions and support them to manage their condition and promote independence. Where telemedicine is in commissioned the Provider must engage with the service.

5.6.9. If support is required for Service Users to access appointments, wherever possible a relative, friend, or representative should take the Service User to such appointments. Where this is not possible, the Provider may be given the option to charge the Service User for an escort for planned health appointments. The Provider has the ultimate responsibility to enable Service Users to attend health appointments outside the Home. Health appointments do not solely mean NHS appointments in hospital. They can include dentist, primary care, optician, etc.

5.6.10. In no circumstances shall charges be applied to unscheduled visits to hospital, e.g. following a fall or collapse. In such circumstances, the Provider will undertake a risk assessment and determine if the Service User is able to attend hospital without an escort. Handover information will be comprehensive and will adhere to local hospital transfer pathway guidance, e.g. Red bag scheme.

5.6.11. The Provider shall inform the Commissioner where the Service User remains in hospital for 4 weeks or more

5.6.12 The Provider will co-operate with the requirements of Red Bag schemes, where available, and ensure that the Service User has the appropriate documentation and personal items with them on entry to hospital, as required by the Commissioner.

5.6.13 The Provider will co-operate with hospital initiated discussions to prepare for a service user's discharge from hospital.

5.7. **PERSON CENTRED OUTCOME 7**

Meeting Communication Needs
Communication with Service Users is conducted in a way that maximises their independence, choice, control, inclusion and enjoyment of rights.

5.7.1. Communication will be conducted in a way that is understandable to the Service User and in a way in which they can make themselves understood based on their individual needs. Service Users say that the way they are communicated with makes them feel better about themselves. If required, referrals will be made to advocacy services to facilitate this process.

5.7.2. The communication needs of each Service User will be identified and include recognition of primary language, visual, hearing and cognitive difficulties. The Provider will ensure they find sources of information and advice and understand how to deal with any difficulties relating to communication.

5.7.3. Communicating in inclusive ways will be dependent upon: -

- A Personalised care and support plan using accurate information on how to get communication right for each Service User. This may be in the form of a communication passport

- Staff awareness and knowledge of a range of resources that support inclusive communication approaches.
- Having and using a range of resources that support inclusive communication
- Enabling the use of digital media e.g. Skype or other similar communication method
- Support from management and senior staff
- Use of relevant external support when required, e.g. Speech and Language Therapy
- Understanding primary language if English is not the Service User's first language

5.7.4. The Provider and staff will communicate and provide information in a format that each Service User and/or their representative can understand.

5.7.5. Service Users will be supported to interact with others and express themselves in line with their individual preferences.

5.8. **PERSON CENTRED OUTCOME 8**

Medication Management
Service Users are protected and supported by the Providers policies and procedures for the management and administration of medication.

5.8.1. The Provider will have clear policies and procedures which demonstrate recognised best practice.

5.8.2. The policies will make it clear who is accountable and responsible for using medicines safely and effectively in the care home. The policies will be evidence based and include the principles of: -

- Sharing information about a Service User's medicines including when they transfer to another care setting
- Accurate and up to date recording keeping and (E)/MAR charts
- Identifying, reporting and reviewing medicines-related problems
- Keeping Service Users safe (safeguarding)
- Accurately listing a Service User's medicines (medicines reconciliation)
- Medication review
- Safe handling of medicines and controlled drugs including ordering, storage and disposal
- Self-administration
- Care home staff administration of medicines including 'when required' medication
- Staff training and competence requirements
- Covert administration
- Homely Remedies/Minor Aliments
- Palliative care
- Verbal orders, and communication with prescribers including adverse reactions
- Administration via a feeding tube
- Correct use of infusions and injection devices in care homes with nursing
- Monitored Dosage Systems and Compliance Aids.

5.8.3. In care homes with nursing, responsibility for medicines administration may be delegated to care staff who will be appropriately trained and assessed as competent. Any delegation must be detailed in a care plan. When the Provider is advised it is not appropriate to delegate medicine administration it must not be delegated. Registered nurses will remain accountable for medicines administration in the home and should provide supervision to care staff undertaking the task.

5.8.4. All Registered Nurses and other relevant staff will complete a medicines management assessment as part of the induction process and provide evidence of ongoing continuing professional development in medicines management.

5.8.5. The Provider will regularly assess and provide documentary evidence of the competency of all Registered Nurses and other relevant staff in the management of medication to ensure that practices are compliant with the standards outlined in the policies and procedures.

5.8.6. Information and advice will be sought from a pharmacist, where appropriate, in relation to administering, monitoring and reviewing medication.

5.8.7. The Provider will ensure that they have an up to date list of medications for each Service User at the start of service delivery.

5.8.8. The Provider will support Service Users to take medicines independently or administer medicines when they are unable to do so.

5.8.9. Records will include details of any capacity assessments and Best Interest decisions made on behalf of any Service User lacking capacity to consent to medication.

5.8.10. Any arrangements for covert medication must be made in accordance with Mental Capacity Act guidance and NICE guidelines. Such arrangements will be clearly documented including medical recommendations, capacity assessment and best interests decision-making record. Where covert medication is given, this will clearly be recorded in the care and support plan and reviewed on a monthly basis.

5.8.11. Any self-administration of medication by Service Users will be undertaken within a risk management framework and suitable lockable facilities provided.

5.8.12. Service Users' medication will be reviewed with their General Practitioner six monthly or more frequently as required. The Provider will support, co-operate with and provider information for the service users medication reviews.

5.8.13. Medication Administration Records (MAR charts) will be audited monthly to provide an audit trail of stock control and storage of medicines including monitored dosage systems and evidence that correct procedures have been followed.

5.8.14. Audits will include monitoring the administration, recording and disposal of medicines. Audits will be robust and comprehensive and identify that measures are in place to ensure safe practice such as: -

- The use of photographs to identify that medicines are being administered to the right Service User (when consent is given by the Service User)
- Specimens of staff signatures to identify care staff or the Registered Nurse responsible for the administration of medication
- The correct and accurate completion of (E)/MAR charts

- Satisfactory procedures for transcribing medication onto MAR charts and recording dosage changes onto MAR charts which include obtaining countersignatures from another registrant or competent health professional.

5.8.15. The Provider will monitor the effect of each Service User's medication and act if their condition changes including side effects and adverse reactions. In addition to this requirement, the Provider will request Service Users taking anti-psychotic medication are reviewed to assess for benefit within four weeks of antipsychotic initiation, which will be evidenced in the care and support plan.

5.8.16. The Provider shall have arrangements in place to record and report drug related incidents including findings of their service review and lessons learnt in order to reduce the risk of repetition, and follow local safeguarding guidance if the threshold is met

5.8.17. Service Users will be notified of any errors in relation to the administration of their medication or their representative, and appropriate medical advice will be taken.

5.8.18. Records will be maintained to reflect the safe disposal of medication.

5.9. **PERSON CENTRED OUTCOME 9**

Privacy, Dignity and Respect
Respect towards Service Users means they are supported and treated in a way that makes them feel better about themselves

5.9.1. The Provider will promote a culture that reflects and demonstrates that Service User privacy, dignity and respect is embedded in the beliefs and values of the service. Service Users will say they exercise choice and control and feel better about themselves because of the way they are treated.

5.9.2. There will be suitable facilities available and staff practices will always enable modesty and protect privacy, particularly when supporting them with their personal care needs.

5.9.3. Staff will uphold Service Users right to confidentiality and the protection of personal information relating to communication and recording. This includes any method of communication individual to the Service User.

5.9.4. Service Users will be cared for in a polite and courteous manner and agreement will be reached with them regarding how they would prefer to be addressed.

5.9.5. Care and support will aim to exercise choice and control and promote the Service User's self-confidence, self-esteem, sense of belonging and wellbeing, and maximise their individual abilities.

5.9.6. Service Users will be treated as individuals, receiving a personalised service encouraging choice and control. They will be listened to and supported to express their needs and wishes.

5.9.7. Staff will not make judgemental statements about the lifestyle or standards of any Service User, either in verbal or written communication.

5.9.8. Service Users will be facilitated to make and receive personal phone calls in private. This will include provision for those who are unable to use a phone independently.

5.9.9. Providers will promote contact between Service Users and their family/friends both in person and over the telephone or by other means.

5.9.10. Where the Provider considers contact between a Service User and any visitor is having a detrimental impact on their well-being, or where visitors are having a disruptive influence on support, those health and social care professionals involved will be notified, and Safeguarding considered. Where risk management requires restrictions on contact with any particular Service User, the Provider will contact the health and social care professionals involved, principles of the Mental Capacity Act will be followed, any best interests' decision shall be recorded with appropriate consideration given to the Service User's right to private and family life.

5.9.11. The Provider will nominate a Dignity Champion within the home, evidence will be available that evaluation has taken place on a regular basis to evaluate and ensure that quality of service that respects a Service User's dignity is being provided e.g. audits or observations.

5.10. **PERSON CENTRED OUTCOME 10**

Autonomy, Choice, Independence and Fulfilment
Service Users are assisted to express informed choice and control over their daily lives and supported in maintaining their personal identity, individuality and independence.

5.10.1. Service Users shall be encouraged, supported and empowered to make independent choices as individuals in order to determine their needs, beliefs, culture, identity, preferences and values.

5.10.2. Service Users shall be supported and empowered to make decisions for themselves and the Provider will take all practicable steps to assist them to make informed decisions.

5.10.3. A Service User's ability to make their own decisions will be assumed unless assessed as otherwise, in accordance with the requirements of the Mental Capacity Act (2005). Service Users shall have the right to think and act without having to refer to others, including the right to decline support.

5.10.4. The Provider will ensure that all staff understand how the Service User's right to autonomy, choice, independence and fulfilment is maintained within the context of the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and other current legislation. Examples could be through training, supervision and team meeting discussions.

5.10.5. Service Users will identify the people they wish to be involved in their life (e.g. partners, relatives, friends) and state how they would like them involved and consent to sharing information will be explicitly gained and recorded. These people will be provided with adequate and timely information so they can be involved in accordance with the Service Users' wishes, which will be reviewed

5.10.6. Service Users and/or their relatives and friends shall be informed of how to contact external agencies (e.g. advocates), who will act in their interests.

5.10.7 Service Users will have a range of information available to assist them to make informed choices about all aspects of their life.

5.10.8 The Provider will ensure that staff support Service Users to access a range of meaningful activities of their choice both within the home and the community.

5.10.9 The Provider will ensure that staff are trained to enable Service Users to maintain their independence.

5.10.10 The Provider will actively listen to the Service User and ensure all their rights are upheld.

5.10.11 The Provider will actively seek the views of the Service User to ensure that they feel they have autonomy, choice, independence and fulfilment.

5.10.12. The Provider will ensure that Service User feedback is proactively gathered to support development of the service and there is evidence that this has been actioned. This could include regular Service User's meetings, consultation on available activities and menu options.

5.11. **PERSON CENTRED OUTCOME 11**

Rights
Service Users' legal rights are respected, protected and upheld.

5.11.1. Service Users are individuals, irrespective of their living situation. They retain all their legal rights and entitlements as individuals when they enter a care home and shall be helped to exercise those rights. This includes participation in government elections and other civil processes.

5.11.2. Service Users human rights under the Human Rights Act 1998 shall be promoted, regardless of their capacity to consent to the support arrangements. Where Service Users do not have capacity to consent to their support arrangements, Providers will conduct all support in accordance with the Mental Capacity Act including:

- Appropriate best interests decision making for any care interventions
- Appropriate respect for private and family life, and the need to refrain from interfering with contact between Service Users and their family/friends without appropriate legal process being followed
- Compliance with Service Users right to liberty and the Deprivation of Liberty Safeguards including
- Granting urgent authorisations where permitted by the legislation and the Deprivation of Liberty Code of Practice
- Making requests for standard authorisations for all Service Users to whom the Deprivation of Liberty Safeguards apply in a timely manner, including renewal applications where applicable. Such applications to be made by secure email to the designated inbox (see section 5.2.7)
- Co-operating with and sharing necessary information with assessors instructed as

part of the authorisation process and appointed Relevant Persons Representatives and Independent Mental Capacity Advocates

- Complying with any conditions placed upon standard authorisations
- Notifying the Supervisory Body of any change in circumstances which would require a review of the authorisation

5.11.3. When a Deprivation of Liberty Safeguards authorisation is granted, the Provider must provide the relevant person information of their rights (including the right to challenge the authorisation), both orally and in writing. This information will also be given to the relevant person's representative.

5.11.4. The Provider is responsible for requesting a further standard authorisation, prior to an authorisation ending, if they consider that the Service User will still need to be deprived of their liberty after the authorisation ends. There is no statutory time limit on how far in advance of the expiry of the authorisation the Provider can apply for a renewal. However, it needs to be far enough in advance for the renewal authorisation to be given before the existing authorisation ends. The Provider must inform the relevant person they have done this.

5.11.5. The Provider will record the name and contact details of the relevant person's representative in the Service User's care and support plan. The Provider is also required to monitor how often the representative visits. If they have concerns that the representative has not been having an appropriate level of contact with the person to enable them to offer effective support, they will consider informing the Supervisory Body.

5.11.6. Service Users shall be assisted to exercise their right to be a full citizen in whichever way they choose.

5.11.7. Service Users' rights will be written into the Provider's statement of values, aims and objectives.

5.11.8. Service Users will have formal mechanisms to be consulted about the running of the home, e.g. residents' meetings

5.11.9. Service Users will have the right to take risks. Risk taking is a normal part of everyday life, so Service Users shall be involved in agreeing any controls or interventions that may be put in place. Risks shall be fully assessed and reasons for actions clearly documented.

5.11.10. Referrals shall be made to Independent Mental Capacity Advocates where appropriate.

5.12. **PERSON CENTRED OUTCOME 12**

Diversity, Equality and Individuality – Expression of Beliefs
Service Users live in an environment that is committed to promoting a culture which respects diversity, equality and individuality and their experiences reflect this commitment.

5.12.1. The Provider will understand and be committed to promoting a culture for both Service Users and staff which reflects and demonstrates that diversity, equality and

individuality is embedded in the beliefs and values of the service adhering to the Equality Act 2010.

5.12.2. A strategic approach will be adopted by the Provider in delivering education to staff so that they understand the: -

- Organisation's aims and objectives
- Relevant policy provisions
- Difference between acceptable and unacceptable behaviour
- How personal attitudes and values can affect behaviour
- Role they play in making the management of diversity a reality
- Meaning of diversity including cultural
- Meaning and impact of discrimination in the workplace.

5.12.3. Service User's beliefs and values will be considered throughout the Provider's assessment process and recorded in the appropriate section of the care and support plans. The Provider will have adequate processes in place to communicate Service Users' individual needs with the staff throughout the home.

5.13. **PERSON CENTRED OUTCOME 13**

Dementia/Mental Health/Learning Disabilities
Service Users whose emotional or mental wellbeing are affected by memory or cognitive impairment or similar condition are assured that the care and support they receive promotes their quality of life.

5.13.1. The Provider shall ensure staff are aware and understand difficulties experienced by Service Users with dementia and mental health issues and how best to support that person. These can relate to emotional and psychological changes including fluctuating mood and disorientation, which may also affect their normal pattern of behaviour and functional ability.

5.13.2. Symptoms of aggression, confusion and disorientation may be as the result of dementia or mental disorder or due a delirium/toxic confused state due to infection, dehydration, constipation or the side effects of medication. Providers shall monitor these aspects to assist with differentiating between causes and symptoms and Service Users shall be referred to a General Practitioner for a physical health review and subsequently where appropriate the GP will refer to a specialist mental health assessment in line with NICE guidelines.

5.13.3. Care and support planning will be completed in collaboration with the Service User and appropriate representative and shall reflect the impact of these symptoms and direct staff how to meet the Service User's individual outcomes and needs.

5.13.4. Staff shall consider Service Users' sense of reality from moment to moment and respond in a way that is meaningful to them and support them to safely express themselves.

5.13.5. Staff shall monitor for changes in a Service User's condition and look for behavioural cues that may indicate a change being required. This may be in the way that care and support is provided or a deterioration that may require a referral to the General Practitioner.

5.13.6. The Provider shall ensure staff work as part of any multi-agency team to support Service Users to include effective liaison with primary mental health services and the Service User's General Practitioner.

5.13.7. Providers shall recognise when their service may need additional support or a more specialised service to meet the needs of Service Users and refer this to the appropriate support services for a review to be instigated in a timely manner.

5.13.8. The Provider shall ensure accurate and person-centred documentation is maintained and is available in a timely manner, staff will receive appropriate and relevant training to complete paperwork.

5.13.9. The Provider shall adapt the physical layout and facilities within reason, day to day routines and staff culture within their service so it allows for a suitably flexible and stimulating environment for each Service User and supports their individuality, their sense of reality, and their mental and emotional wellbeing. This includes religious beliefs and practice and privacy and dignity around sexuality.

5.13.10. The layout and facilities will help Service Users to understand and make use of all spaces and facilities. It will support Service Users' abilities and maximise their independence; limiting the impact of their disabilities and minimising confusion and distress.

5.13.11. Security and other safety arrangements for the building, garden and other areas and activities will mean that Service Users freely use facilities whilst being protected from harm.

5.13.12. The Provider will ensure that there are opportunities for Service Users with memory and/or cognitive impairment to access the outdoors on a regular basis where this is beneficial to their wellbeing. If the home has a garden, it should to be maintained in such a way that it can be utilised safely by all Service Users.

5.13.13. The Provider shall organise staff to allow time for supporting Service Users in groups or one-to-one to include, where relevant, connections to social network, community facility or external environment that is meaningful to them. Evidence of this shall be clearly recorded.

5.13.14. The Provider shall arrange for the environment, surroundings, daily routine and the way staff behave to uphold the mental and emotional wellbeing of Service Users, inline with current best practice guidance.

5.13.15. The Provider will ensure that staff have the necessary training, skills and knowledge of people's individual needs and behaviour in order to deliver effective person-centred care including and not limited to;

- Interpersonal skills in communication including non-verbal
- Adapting own behaviour to promote relationships
- Build meaningful interactions to include promoting empathy and unconditional positive regard, maintaining Service User's personal world, identity, personal boundaries and space
- Recognise the signs of anxiety and distress resulting from confusion, frustration or unmet need and respond by understanding the events the Service User is experiencing and diffusing their anxiety with appropriate therapeutic responses

- Monitoring and effectively reviewing the effects and side effects of specialist medications e.g. anti-psychotic medication
- Meaningful occupation/activities and stimulation as a part of effective therapeutic intervention and care and avoiding isolation. Understanding the changing nutritional care needs of those with dementia and providing services and support in a flexible, person-centred manner
- Being flexible about the physical layout, facilities and routines
- Effective management of behaviours that challenge and how agitation and aggression is a method of communicating unmet need
- Risk assessment and management, emphasising freedom of choice and reasonable risk taking
- Promoting social and community networks and relationships.

5.13.16. Where appropriate, the home has a lead, for example a Dementia Champion, to role model, coach and embed training into practice, and to monitor the quality of dementia care.

5.14. **PERSON CENTRED OUTCOME 14**

Managing Behaviours that Challenge
Service Users who present behaviour that challenges services are supported in a way that helps them to communicate and to safely deal with situations they find difficult.

5.14.1. The Provider shall ensure the application of practice that focuses on person-centred and positive support to Service Users whose behaviour challenges in line with good practice guidance.

5.14.2. Positive Behaviour Support shall be planned in a proactive way that reduces the likelihood of behaviours that challenge happening. There will be a focus on preventative strategies, identification of early warning signs and plans will show staff how to support Service Users in an individual way that meets their needs. The care and support plan will direct staff on how best to respond to a Service User when they are displaying behaviours that challenge which supports de-escalation of the situation.

5.14.3. The Provider must work in line with the principles of the Mental Capacity Act 2005; all forms of restrictions and restraint will be proportionate to the harm being prevented and in the Service User's best interest where the Service User lacks the capacity to make the decision. The Provider will consider a Deprivation of Liberty application.

5.14.4. Interventions used to control behaviours that challenge shall always be the least restrictive for the minimum amount of time and only considered when all other options have been exhausted. Physical restraint and medical intervention for behaviours that challenge will always be discussed and documented with all parties involved.

5.14.5. The Provider will ensure that where physical restraint is necessary, that techniques and approaches pose the least risk to the Service User and staff are supported in understanding individual approaches.

5.14.6. The Provider will ensure staff are suitably trained and competent in implementing proactive and preventative strategies to manage and de-escalate situations where individuals display behaviours that challenge. Where physical restraint is required for Service Users, the Provider must ensure staff receive regularly updated training, at least annually, in line with NICE guidelines and a relevant industry best practice, such as the Restraint Reduction Network (RRN) Training Standards.

5.14.7. Following incidents where restraint has been used, the Provider shall have a clear process for recording and debriefing for the staff team and involve the service user where this is possible. This will provide opportunities to reflect on the practice, to learn from situations and how similar incidents could be prevented. Where appropriate, changes to the Service User's care and support, staff approaches or referrals to Professionals will be clearly documented.

5.14.8 Where there is involvement from external health professionals, the care and support plan will be based on any assessment and/or recommendations. The care and support plan will identify what behaviours need to be addressed based on what is important for the Service User and an assessment of risk. An understanding of the reasons for these behaviours shall be determined with the Service User and others involved in their life.

5.14.9. The Provider will support Service Users to be involved in all aspects of their care and support planning wherever possible, taking into consideration their individual needs and functioning. Where they are unable, an appropriate representative will be involved, and documentation should be clear.

5.14.10. The plan shall involve, as relevant, appropriate Local Authority and Health Teams and Professionals involved in the Service User's care and support e.g. General Practitioner, Community Learning Disability Team, Community Mental Health, Rapid Intervention and Treatment Team (RITT), Recovery Team for Older People, CHESS team, Dementia In-Reach Team, Intensive Support Team.
The Provider will ensure there is evidence of on-going multi-disciplinary working and effective liaison with specialist services.

5.14.11. The care and support plan shall include procedures to be followed after an incident of behaviours that challenge to include a description of how the Service User is likely to look and behave as they recover, along with details of the support the Service User requires at this time.

5.14.12. The care and support plan must consider all aspects of the Service User’s life including life story work to inform how to meet their physical, mental, social and emotional wellbeing and how this has an impact on their behaviour. The plan will identify what behaviours need to be addressed based on what is important for the Service User including an assessment of risk.

5.14.13. The care and support plan shall be recorded to ensure all those providing support use a consistent approach including: -

- a description of the Service User’s behaviour
- a summary of the most probable reasons underlying the Service User’s behaviours that challenge
- proactive and preventative strategies
- reactive strategies
- incident briefing

- monitoring and review arrangements
- implementation arrangements
- who was involved in devising the plan

5.14.14. Separate risk assessments and plans will be devised as necessary for specific situations (e.g. car journeys, around food).

5.14.15. Care and support plans shall be reviewed and updated on a regular basis and at other times when there is a change that may impact on Service Users or following an incident of challenging behaviour.

5.14.16. A risk assessment of the impact of potential incidents of behaviour that challenge on staff and other service users needs to be taken into consideration, using the lessons learnt to ensure that the home has appropriate staffing levels to deliver the care required.

5.15. PERSON CENTRED OUTCOME 15

Social Contact, Activities and Community Contact
Service Users are supported to spend their time in a way that matches their preferences, and meets their needs for social, cultural, religious, educational and recreational participation.

5.15.1. Service Users will be supported to spend time, of their choosing in a way that is meaningful and stimulating for them via activities made available by the Provider and those accessed by the Service User themselves. This may include leisure and recreational activities in and outside the home, which suit their needs, preferences, aspirations, lifestyle, choices and capacities. Service Users will be empowered to increase and maintain confidence, enhance self-esteem and to minimise social isolation. Evidence of this will be recorded in care and support plans.

5.15.2. Service Users will be encouraged to exercise their lifestyle, cultural and spiritual beliefs through both planned and spontaneous activities.

5.15.3. Staff facilitating group or individual activities will be appropriately trained and skilled to deliver effective and meaningful activities that are suitable to meet individual needs and supports the Service User to maintain their independence.

5.15.4. Consideration of meaningful activity provision will be given to Service Users with needs which means they may not be able to fully participate in activities without support. This could include dementia and other cognitive impairments, those with sensory impairment, those with physical disabilities or learning disabilities and Service Users who are unable to access communal areas within the home.

5.15.5. The Provider will support Service Users to access available resources from organisations with specialist knowledge and expertise.

5.15.6. Where appropriate, comprehensive life histories will be undertaken in partnership with the Service User and/or their representative and a plan of care developed so that past and present life experiences, along with priorities for the future, can be agreed and met. The Provider should be able to evidence attempts to undertake and any refusals to undertake

life history work.

5.15.7. Service Users will be supported to have visitors, in line with their wishes and links with family, friends and local community will be in accordance with individual preference.

5.15.8. Up to date information about activities in and outside the home will be available to all Service Users in formats that meet the needs of individuals.

5.15.9. Service Users' participation in activities will be recorded and evaluated regularly to ensure that outcomes and Service User needs continue to be met.

5.15.10. Service Users will be fully involved in activities planning in the home and have opportunities to influence the range of activities offered by the Provider.

5.15.11. Service Users will be supported to be involved in community groups, should they indicate a preference to do so, in order for them to be able to influence the wider health and social care agenda.

5.15.12. Where the Provider provides transport for the Service Users for purposes not covered by their assessed need, e.g. Home mini-bus for private outings, the Provider may agree a reasonable rate of payment for the transport. If external transport is used, e.g. taxi, the Service User is expected to pay for such transport.

5.15.13. The Provider will make every effort to connect with the local community to support the development of new connections.

5.15.14 The Provider will engage with the relevant community/neighbourhood teams (where appropriate) and assist residents to access to a wide range of health, social care and community-based support and services within the Lancashire and South Cumbria locality.

5.16. **PERSON CENTRED OUTCOME 16**

Pressure Area Care, Tissue Viability and Wound Management
Service Users receive care that supports healthy tissue viability and wound management. (Localisation)
Delivery of elements of this Outcome will differ for Homes registered with the Care Quality Commission to provide nursing care and those registered as a residential home. The latter will receive support from local District Nursing Teams, who will work within their own organisational policy.

5.16.1. The Provider shall have up to date policies and procedures to support tissue viability and wound management practice. The Provider will ensure that staff have evidence of training and embed requirements in their practice and have a pressure care champion to deliver training for staff.

5.16.2. The Provider will provide Service Users with care and support to prevent and manage pressure ulcers in line with NICE good practice guidance and other preventative models of recognised pressure prevention methodology.

5.16.3. Tissue viability interventions and wound management shall be overseen by

competent Registered Nurses (either employed by the Provider or through community nursing services) with up to date knowledge and skills in the prevention, assessment and management of pressure ulcers and management of wounds.

5.16.4. Wound management will consider Service User's individual needs, preferences and compliance with both treatment and the care and support plan. Clear communication of essential information will enable the Service User to make informed decisions about their care.

5.16.5. Wound care documentation will be descriptive and directive incorporating a holistic assessment of the Service User's individual health needs, links into risk assessment, predisposing factors, include a rationale for the selection or change of a treatment or dressing and document clinical outcomes. Documentation will include planned preventative strategies and plans for reassessment.

5.16.6. The Provider will complete an examination of skin integrity on admission to the home, when transferred to or from hospital or where injuries e.g. bruising, red areas, pressure ulcers, cuts, wounds or burns are identified. Findings of the examination will be recorded on a body map, and if relevant a safeguarding alert will be made as required by local guidelines

5.16.7. Wound assessments and care and support plans will include: -

- The location and measurement (grade and dimensions) of the wound demonstrated by a wound map and photograph (with the Service User's consent or documentation around BIA/LPA)
- A record of any underlying or undermining intrinsic and extrinsic factors that may have contributed to the wound for example general health status, malnutrition, systemic disease, poor mobility or medication
- A description of the colour or appearance of the wound bed and status of the surrounding skin, including any undermining/ tracking sinus or fistula
- A record of any exudate, pain or malodour
- A rationale to support the selection of a treatment or dressing which may be determined by the type and position of the wound, the amount of exudate, pain, odour, any known allergies, the Service User's compliance/concordance with the dressing and the frequency of dressing changes. The wound will be evaluated and reviewed at each dressing change and documented accordingly.

5.16.8. Wound care documentation will clearly document clinical outcomes and provide a chronological history of the progress or deterioration of the wound demonstrating regular evaluation and review and any specialist input or referral.

5.16.9. Care homes without nursing will liaise with the relevant health professional if they have any concerns in relation to skin injuries and pressure areas/pressure area care and will follow the guidance provided. This may include advice in relation to (but not exclusively) hygiene, repositioning regimes or appropriate equipment to be used. Such guidance will be clearly documented in the care and support plan.

5.16.10. An appropriate and evidence-based risk management tool shall be used to assess risk and where necessary an action plan put in place. A baseline risk assessment shall be undertaken within six hours of admission to the home and reviewed regularly thereafter.

5.16.11. Staff will be trained to identify Service Users most likely to develop pressure ulcers and will be competent to recognise pre-disposing risk factors as a part of both the pre-

admission assessment and on-going assessment process.

5.17. **PERSON CENTRED OUTCOME 17**

Nutritional Care
Service Users have enjoyable mealtime experiences that meet their individual needs and that mean they eat what they like when they want it.

Nutritional Care Requirements

5.17.1. The Provider will ensure that Service User's nutritional care needs are considered which will also support independence and facilitate an enjoyable mealtime experience, assessments should include but not limited to the following areas:-

- Personal aids and equipment
- Day to day choices of food and drink
- Food and fluid consistencies
- Special dietary requirements
- Food and beverage preferences
- Where Service Users wish to eat each meal, at what time and with whom
- Good physical positioning
- Cultural, ethical/moral and religious beliefs
- Level of assistance required which may include encouragement as well as physical support
- Special occasions to be celebrated

5.17.2. Nutrition and hydration risks and needs, including allergies and intolerances, will be included as part of the holistic pre-admission assessment. See Outcome 2 for further information on pre-admission assessment. This information should be regularly updated and reviewed as more person-centred information is gathered, preferences change or medical/nutritional needs change.

5.17.3. All staff must follow the most up-to-date nutrition and hydration assessment for each Service User, the Provider shall have a process in place to notify staff of any changes to diet and hydration needs including nutritional care requirements, modified textures. Care plans should be updated at the time of these changes to be reflective of current need.

5.17.4. Providers must follow Service Users' consent wishes if they refuse nutrition and hydration unless a best interest decision has been made under the Mental Capacity Act. Other forms of authority, such as advance decisions, should also be considered.

5.17.5. Consideration and recognition will be given when Service Users are coming to the end of life phase, as nutritional needs change and reduce according to disease progression. During this phase all staff will ensure that good mouth care and comfort is a priority.

5.17.6. Service Users will be supported to maintain good oral hygiene to promote comfort, increase appetite, enable ease and safety of eating and drinking, avoid infection and improve overall quality of daily living.

Nutritional Screening

5.17.7. On admission to the service, the Provider will nutritionally screen all Service Users using the Malnutrition Universal Screening Tool (MUST) or appropriate alternative tool. This will be reviewed on a monthly basis as a minimum (excluding those identified from a Multi-Disciplinary Approach as requiring End of Life care) or sooner when there is a clinical concern or change in need.

5.17.8. Where Service Users are found to be at medium or high risk of malnutrition, their care plan will clearly outline what specific support is required and all care and catering staff will be made aware of actions to take.

5.17.9. Strategies and actions to manage the risk of malnutrition and dehydration will be individual to the person but should include consideration of:-

- Food and drink fortification
- Documenting and monitoring food and fluid intake
- Nourishing drinks and homemade supplement drinks
- Increase in frequency of food and drink being offered
- More regular nutritional screening and weighing
- Referrals to other Professionals as appropriate including General Practitioner, Speech and Language Therapist, Registered Dietician and / or Occupational Therapist

5.17.10. Where completion of food and fluid charts are included in a Service User's plan of care, information should be recorded as accurately as possible and should be used as part of the review process to determine if further interventions are required. Staff should respond in a timely manner to address concerns or issues identified. Charts should include the following information but not limited to:-

- Details of food and drink offered and taken including type and quantities
- Information on how food and drink has been fortified
- Food and drink refused
- Alternate options offered
- Individual fluid target and fluid totals
- For some Service Users recording urine output and bowel movements may also be necessary

5.17.11. As part of the Provider's governance process, the accuracy of nutritional screening using MUST or equivalent tool should be audited quarterly and where required, any areas for improvement identified should be actioned.

5.17.12. Providers will ensure that equipment and scales used to measure Service User's weight and height are suitably and regularly calibrated and maintained in order to provide reliable and accurate measurement.

Dietary Supplements and Thickeners

5.17.13. Prescribed dietary supplements and thickeners will be used in accordance with the medication policy and subject to the terms of the prescription. The International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines and framework to standardise the terminology and definitions to describe texture modified foods and thickened fluids will be followed.

5.17.14. If food or fluid texture is required to be modified, then catering and care staff will be aware of the relevant descriptor recommended by the Speech and Language therapist.

Menus

5.17.15. Menus and meals will reflect the ethnic, social, cultural and religious needs of the Service Users and include general programmes of events e.g. Pancake Day, Passover etc.

5.17.16. Menus will offer adequate hot and cold choices appropriate to the needs of the Service Users e.g. dysphagia needs or service users requiring finger foods. Menu cycles will be over a minimum of three weeks, seasonal and all meals and snacks will be recorded.

5.17.17. Service Users will have a choice of meal options each day and where required, will be offered support to make their choices in line with their assessed needs.

5.17.18. The Provider will actively involve Service Users in the development of menus and ensure they are provided with opportunities to give regular feedback on this e.g. choice, variety, availability, presentation quality and quantity.

5.17.19. Information about allergens used within the food made and served will be available and updated as and when menu changes occur and when suppliers/brands of ingredients change.

Meal Times

5.17.20. Mealtimes should be enjoyable experiences and promoted as a social activity. Dining rooms and other eating areas should be pleasant, environments conducive to eating that are welcoming, clean, tidy and free from malodours. Dining spaces need to reflect the needs of Service Users.

5.17.21. If the nutritional care requirements highlight assistance or encouragement to eat and drink is required, it shall be provided ensuring sensitivity and respect for Service Users' dignity and individual abilities. Enough staff will be available to support those in need of assistance and/or encouragement to eat.

5.17.22. Service Users will be enabled and encouraged to serve themselves where assessed as able and safe to do so; a family style food service will be encouraged.

5.17.23. Food, including that which is texture modified, will be presented in an appetising way that respects dignity.

5.17.24. Protected meal times (an environment conducive to Service Users enjoying their meals and being able to safely consume their food and drink without being interrupted by non-urgent activities) will be encouraged, Service Users will be able to invite friends and family to join them but will not be disturbed by other interruptions e.g. GP's, hairdressers etc.

5.17.25. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.

Hydration

5.17.26. Water must be available and accessible to Service Users at all times. Other drinks will be made available periodically throughout the day and night and Service Users will be encouraged and supported to drink. Suitable adjustments should be made for seasonal changes.

5.17.27. Staff will be aware of the possible early warning signs and symptoms of inadequate

hydration and take appropriate action to address these signs, based on the presentation of the person. Actions should be undertaken to counteract warning signs such as pushing fluids through a range of high fluid content alternatives and contacting the GP where this is felt necessary.

Training

5.17.28. The Provider will ensure staff receive appropriate induction and ongoing training to enable them to carry out their role effective supporting effective management and monitoring of Service Users' dietary and hydration needs including but not limited to:-

- All care and catering staff will be trained in the importance of good nutrition and hydration, how to recognise the signs of poor nutrition and hydration and how to promote adequate nutrition and hydration.
- All staff responsible for undertaking nutritional screening will be trained in the use of the validated screening tool e.g. MUST.
- Staff involved in the handling, preparation of food or assist at mealtimes receive training in Food Safety and Hygiene.
- Where appropriate to the needs of the Service Users within the home, additional training may be required such as diabetes management, thickened fluids, dementia, chronic illness or management of swallowing difficulties.

5.18. **PERSON CENTRED OUTCOME 18**

Complaints
Service Users and their relatives and friends are confident that their complaints and concerns will be listened to, taken seriously and acted upon effectively without any negative impact.

5.18.1. The Provider will operate a complaints procedure. This will be easily accessible and allow Service Users, their carers or advocates to make a complaint, raise concerns or appeal. Response times / expectations are clearly stated within the complaints procedure.

5.18.2. The Provider shall demonstrate a positive and open attitude to complaints and facilitate verbal or written complaints to be made or made on behalf of the Service User and shall not seek to obstruct, delay or interfere with the Service Users' rights in this regard.

5.18.3. The Provider will ensure that all complaints are thoroughly investigated by a competent person and records are kept demonstrating how they have been managed, a timescale for responses and how Service Users are informed of the outcome including their level of satisfaction.

5.18.4. Actions taken or changes made as a result of concerns, complaints or grievances to address problems and shortfalls will be identified within and across the organisation. Such action will also include learning and improvements implemented as a result of complaints and concerns and will be audited on a regular basis for themes and trends.

5.18.5. The Provider shall provide contact details for other relevant organisations for Service Users to escalate complaints outside of the Provider's organisation.

5.18.6. The Provider will record compliments and use them to learn from positive

experiences.

5.19. **PERSON CENTRED OUTCOME 19**

Safeguarding Adults
Service Users live in an environment where they are confident that the Provider will take practical measures to prevent harm from occurring and will safeguard them in a way that supports them in making choices and having control about how they want to live.

5.19.1. The Provider will have robust procedures in place for safeguarding Adults at Risk and responding to concerns (including "whistle-blowing") of abuse/neglect to ensure the safety and protection of Service Users.

5.19.2. The Provider's procedures will reflect the local Safeguarding Adults policy. The Provider will ensure a copy of the local Safeguarding Adults policy and Procedures is available and accessible to all staff For Lancashire Safeguarding Adults Board organisations this includes the Guidance for Safeguarding Concerns

5.19.3. The Provider's employees will follow the procedure set out in their organisations' policy and that of the Local Safeguarding Adults Board immediately if they suspect that a Service User or otherwise dependent person has suffered any form of abuse or is otherwise thought to be at risk.

5.19.4. The Provider will clearly display in formats accessible to all what service users, staff and visitors should do to report any suspected abuse.

5.19.5. Preventative practice will be in place to support safeguarding, including employment, management and security of the environment.

5.19.6. The safety and wellbeing of the Service User will be paramount and, in the event that an alleged abuser is a member of staff or a volunteer, action will be taken immediately to ensure the protection of Adults at risk(s) from the possibility of further abuse while an investigation is carried out. This will also apply where the alleged abuser is the Registered Manager/Person in charge.

5.19.7. The Provider will co-operate fully in any safeguarding enquiries and comply with any agreed requirements of a safeguarding/risk management plan which may include a referral by the Provider to the Disclosure and Barring Service and/or the Nursing and Midwifery Council. Failure to comply with procedures or outcomes/actions from safeguarding enquiries may be regarded as a fundamental breach of the Lancashire County Council contract for the Provision of Older Adults Residential & Nursing Care Services contract.

5.19.8. Training in Safeguarding, including whistleblowing, will be explicitly included in induction and ongoing training for all staff and volunteers employed by the Provider and updated every three years.

5.19.9. The Provider will ensure that systems within the home protect Adults at Risk in accordance with the legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

5.19.10. The Provider' management practices ensure controls will be instigated to protect victims of alleged abuse/neglect from alleged perpetrators during investigations.

5.19.11. The Provider will ensure whistle-blowers are protected from adverse treatment.

5.19.12. The Provider will seek advice at the earliest possible opportunity if they are unsure if a concern should be raised through the safeguarding procedures.

5.19.13. The CQC must be notified of incidents and events that are required to be reported to them.

5.19.14. The CQC must be notified under its health and safety regulation when someone has suffered harm.

5.19.15. The Provider should pay due diligence to the duty of candour and offer apology in accordance to this.

5.19.16. The Provider will offer the opportunity following the conclusion of safeguarding enquiries if the Service User or their relative wishes to make a complaint. They will also be given the option of referral through to independent advocacy, e.g. http://www.government-online.net/advocacy-services-for-lancashire-county-council/)

5.19.17. The Provider will actively engage with the LSAB Safeguarding Adult Reviews (SAR) as appropriate; enabling staff, where relevant, to attend and contribute to practitioner events and facilitate sharing and embedding of any learning that may result.

5.20. **PERSON CENTRED OUTCOME 20**

Safe Working Practices/Health and Safety
The health, safety and welfare of residents and staff is promoted and protected. Procedures are in place to ensure the safety of Service Users in the event of an emergency.

5.20.1. The Provider will ensure that staff are provided with accredited risk management, health and safety, moving and handling and falls prevention training. Moving and handling refresher training or competence assessment will be provided yearly as a minimum. Refer also to clause 5.26.15 regarding staff training.

5.20.2. The Provider will have clear processes in place for the prevention and management of falls.

5.20.3. Serious untoward accidents and incidents, COSHH and RIDDOR will be reported to the appropriate body, for example, Health & Safety Executive, Health Protection Agency and the Care Quality Commission. Details will also be copied to the local authority's contract management team at contractmgmt.care@lancashire.gov.uk

5.20.4. Individual risk assessments relating to the health, safety and welfare of Service Users must be completed and reviewed regularly.

5.20.5. Assessments, planning and delivery of care will be based on risk assessments and include measures to mitigate risks to Service Users, this will be reviewed and amended to address changing needs or practice.

5.20.6. The Provider will ensure the decontamination of medical devices, maintenance of

reusable equipment and appropriate use and disposal of single use equipment.

5.20.7. There will be evidence of awareness of Department of Health Medical Device Safety Alerts.

5.20.8. Fire precautions shall be in place and include Fire Safety Training for all staff and conform to HM Government guidelines, 'Fire Safety, Risk assessment, Residential Care Premises 2006' or subsequent guidelines.

5.20.9. A Fire Risk Assessment shall be in place which is reviewed annually or when there is a significant change to your premises or Service Users. Fire safety records shall be maintained and used to manage compliance with fire safety law.

5.20.10. The Provider shall maintain a Fire Emergency Plan and Evacuation plan appropriate to the establishment and the Service User group. The Provider will ensure that Service Users, staff and visitors are aware of an emergency plan and escape routes.

5.20.11. For Service Users who are not able to reach a place of safety unaided or within a satisfactory period in the event of an emergency, the Provider will create Personal Emergency Evacuation Plans (PEEPs), where possible in conjunction with the Service User to agree what type of assistance is needed and appropriate arrangements put in place. PEEPs will be reviewed on an ongoing basis, every six months, or if there is a change to the Service User's needs for example health, mobility, medication or behaviour.

5.20.12. A trained First Aider will always be on duty.

5.20.13. The Provider shall ensure that all staff, including temporary or agency, are aware of the procedures for dealing with medical emergencies and calling emergency services.

5.20.14. The Provider shall maintain a business contingency plan which protects the Service Users who use the service in the event of an emergency, e.g. loss of power, loss of heating, sudden staffing shortage, flood, and which clearly designates roles and responsibilities of employees on duty. The Provider will ensure all staff are fully aware of their individual and collective roles in the procedures to adopt in the event of an emergency.

5.20.15. The Provider will have a written procedure for dealing with situations where a Service User is missing which includes informing the Registered Manager (or their representative) immediately and the Police. At the earliest opportunity the relatives will also be informed, even if the Service User has subsequently returned. The Provider will also inform the local authority at the earliest convenience via 0300 123 6720 / ACSCustomer.Services@lancashire.gov.uk

5.20.16. The Provider will have a written health and safety policy and organisational arrangements for maintaining safe working practices which are evident and understood by Service Users and staff.

5.20.17. The physical environment will be fit for purpose and safe for Service Users and staff.

5.20.18. The Provider will ensure that equipment is available to Service Users and that they adhere to key legislation relating to Equipment Safety, ensuring that equipment is well maintained and visually checked before use, any defects, damage or wear is reported and actioned.

5.21. **PERSON CENTRED OUTCOME 21**

Infection Prevention and Control (IPC)
Service Users reside in a clean environment where standard precautions and safe practice ensure that avoidable infections to Service Users, staff and visitors are prevented.

5.21.1. The Provider shall ensure that policies or procedures are in place to protect Service Users, staff and visitors from Health care Associated infection (HCAI). These should include:-

- Environmental hygiene
- Optimum hand hygiene in accordance with WHO 5 moments and adherence to 'Bare Below the Elbows' when carrying out personal or clinical care
- Safe handling and disposal of clinical waste
- Managing accidents, dealing with spillages, especially body fluid spillages
- Provision, wearing and disposal of personal protective equipment and clothing
- Service User hygiene including hand hygiene
- Cleaning and decontamination of reusable equipment
- Management of laundry and soiled/infected linen
- Management and disposal of sharps and inoculation injury
- Reporting of Health Care Acquired Infections (HCAI's) and engagement in the Post Infection Review process
- Management and notification of infectious diseases, including outbreak control
- Clinical procedures compliant with aseptic technique
- Safe procedure for the collection and storage of specimens
- Management of indwelling devices
- Staff training and education including IPC lead and Care Champion. IPC induction and mandatory training
- Prevention and control of Legionella bacteria including an up to date Legionella assessment with a plan of preventative maintenance to include monthly testing and recording.

5.21.2. Infection control procedures will be explicitly referred to within all staff job descriptions, induction, development and on-going training for all staff. The Provider will have a designated lead/link person for infection prevention and control

5.21.3. The environment will be designed and managed to minimise reservoirs for micro-organisms and reduce the risk of cross infection to Service Users, staff and visitors. The premises should be kept clean, hygienic and free from offensive odours throughout. Laundry facilities should be housed in a separate room which is not to be used for any other purpose. The room should have a dirty to clean workflow system. Sluice facilities should not be housed within the laundry.

5.21.4. The Provider will comply with optimum hand hygiene in accordance with WHO 5 moments and adherence to 'Bare Below the Elbows' when carrying out personal or clinical care
Hand washing facilities will be prominently sited in areas where infected material and/or and health and social care waste are being handled and this will include liquid soap and disposable hand towels.
Service User hygiene including hand hygiene will be promoted.

5.21.5. Protective equipment will be available and worn for all aspects of care which involve contact or potential contact with blood or body fluids or where asepsis is required.

5.21.6. All Service Users' equipment will be cleaned and maintained appropriately to prevent cross infection.

5.21.7. A local outbreak policy will be in place for the surveillance, recognition, control and management of infection and outbreaks with information available to Service Users and their visitors. Staff will be trained and aware of actions to take including reporting to Public Health England. All infection outbreaks will be reported to Public Health England within two days of an outbreak.

5.21.8. Notifiable diseases and infections that could be a potential risk to others will be recorded and reported to Public Health England, local Environmental Health and the Care Quality Commission in accordance with local arrangements.

5.21.9. An annual Infection Prevention and Control assessment will be completed, and an action plan developed to address any areas of non-compliance.

5.21.10. Monthly audits will be undertaken to determine best practice is maintained and include incidence/prevalence rates for HCAI wound infections, urinary tract infections, notifiable infections, antibiotic prescribing, hand washing and decontamination of equipment.

Audits will be carried out to ensure staff follow correct infection prevention and control measures.

5.21.11. The Provider will have a policy/guidance for staff on transfer of information relating to infections when Service Users are admitted to hospital or another care environment to ensure that information related to infections will be shared with other health and social care providers.

5.21.12. The Provider will engage in the Post Infection Review for specific infections as required.

5.22. **PERSON CENTRED OUTCOME 22**

Accident/Incident Reporting
The safety and wellbeing of Service Users is assured through the Provider's Accident and Incident Reporting processes. Lessons are learnt from accident/incident/near miss reporting processes

5.22.1. The Provider's policies will reflect the procedures to be undertaken following an accident or incident and staff, including agency and any temporary staff, are fully aware of the processes.

5.22.2 The Provider will have a policy around what actions will be taken following an injury. Regular checks on staff awareness of said policy will be undertaken through staff 1 to 1's/supervisions/PDR and Team Meetings.

5.22.3 The Provider will adhere to reporting procedures as required by the commissioner

5.22.4. All accidents and incidents will be comprehensively and contemporaneously documented. Within a care home with nursing, such records must be completed or countersigned by a registered nurse.
Additional records, such as falls diaries and behavioural charts will be implemented and maintained daily/weekly/monthly as appropriate to support ongoing monitoring and management. These records will be audited regularly by the Provider's management team/nominated individual to ensure that consistency and accuracy of information is maintained and to be reviewed regularly against risk assessment records.

5.22.5. Details of accidents and incidents will also be recorded within Service Users' daily records together with information to reflect the Service Users' health, safety and wellbeing. This information will be audited regularly by the Provider's management team/nominated individual to ensure that consistency and accuracy of information is maintained, and appropriate risk assessment reviews are carried out as part of a Service User's care and support plan.

5.22.6. Injuries, including bruises that are sustained following an accident or incident, shall be fully documented, using body maps where possible. Treatment required following an accident or incident will be clearly documented, including the precise treatment and support and any necessary health or social care professional input i.e. Paramedics, District Nurses, General Practitioner, Community Psychiatric Nurses.

5.22.7. From audits undertaken in respect of accidents and incidents a comprehensive monthly analysis will be undertaken and documented to identify themes, patterns or trends in order to investigate and put in place timely measures to minimise or prevent such events reoccurring.

5.22.8. Repeated accidents and incidents, such as falls or aggressive behaviour, will be referred to specialist health and/or social care professionals to seek support and guidance in managing such situations effectively and in the best interests of the Service User. This will evidence a dynamic approach which attempts to pre-empt hazards/potential triggers and a proactive response before an incident occurs. All contact with external professionals will be recorded and any advice or guidance given will be reflected within a Service User's care and support plan updates.

5.23. **PERSON CENTRED OUTCOME 23**

End of Life Care/Dying and Death
Every person living in a care home gets the high-quality, genuinely compassionate care they should expect, and that through the care and support that they receive, live as well as possible until they die

5.23.1. End of Life care relates to the last 12 months of life. Good end of life planning will ensure that the Service User's wishes are acknowledged and recorded and that the Service User remains at the centre of all decisions. The Provider will have a policy which reflects NICE quality standards QS13 end of life care for adults and QS144 care of dying adults in the last days of life.

5.23.2 The Provider will work with other health care professionals and in particular, GP's to pro-actively identify Service Users who may be approaching the end of life and support a regular coordinated review of care.

5.23.3. Providers in Lancashire will abide by the Lancashire Safeguarding Adults Board guidance regarding DNACPR (http://www.lancashiresafeguarding.org.uk/media/34232/care-home-practitioners-dnacpr-guidance-review.pdf)

5.23.4. The Provider shall ensure that the appropriate planned comfort, support and compassion is provided to Service Users when it is recognised that they are entering the end of life phase. Sensitive open and honest communication will take place with the Service User, and all decisions will be taken in line with their wishes which will be appropriately reviewed with the Service User and their family or representative should the Service User wish. Any advance care and support plan wishes will also be considered at this time. This will include decisions made by the Service User about their care or treatment. The home will respect a Service User's advance care plan and offer support to meet any dying wishes wherever possible.

5.23.5 The Provider will support timely return of patients from hospital to their home when it has been identified they are approaching the end of life and their preference for place of care is the home.

5.23.6. Service Users will be referred in a timely manner to specialist services, in line with local referral policies where required.

5.23.7 The Provider will have the equipment, where appropriate, to support care at end of life for e.g. syringe drivers and be able to evidence that staff trained to be able to use the equipment

5.23.8. The Provider shall provide a quiet and comfortable private space for Service Users and those people who are important to them, to remain close in the last days of life. Relatives and partners will be able to spend as much time with Service Users as they wish in line with Service Users' individual preferences, and where possible accommodation and refreshments will be available for relatives who want to stay/sleep overnight at the home.

5.23.9. All deaths will be managed with dignity and propriety and Service Users' spiritual needs, rites and functions will be observed. There will be systems in place to ensure, when death is expected, that Service Users do not die alone unless it is their wish.

5.23.10. Where Service Users require end of life or palliative care, an assessment will be co-ordinated by an appropriately trained nurse to assess whether the right care can be provided by the existing Provider, or by other relevant professionals, and any changes required are actioned in a timely manner. All assessments will be subject to continuous ongoing review.

5.23.11. The nursing assessment will involve advance care planning (ACP) where possible, to determine Service Users' wishes, indicating personal preferences concerning place of care and death, in agreement with carers and family and will include Service Users' wishes relating to resuscitation, if this is stated. Utilise nationally or locally recognised ACP tools and documentation.

5.23.12. Sensitive and compassionate end of life care be co-ordinated and delivered in accordance with Service Users' personal care and support plan. Service Users' end of life care will be planned to include relatives or important people in their lives if desired, so that Service Users and relatives know what will happen and are able to prepare.

5.23.13. Clear, accurate and dignified records will be maintained and meet the standards for record keeping of the relevant professional groups.

5.23.14. A keyworker will co-ordinate Service Users' care pathway and ensure continuity of care including out of hours support.

5.23.15. The home has an end of life champion who has a clearly defined role and is supported to carry out their duties effectively.

5.23.16. The home will have a plan in place for respecting and remembering the Service User after they have passed away.

5.23.17. The care pathway will include care after death and information on support agencies and bereavement counselling.

5.23.18. There will be a policy and procedure in place for the verification of death and verification of expected death (if appropriate by competent registered nurse).

5.23.19. The Provider will ensure compliance with the National Institute for Clinical Excellence NICE 2011 End of Life Care Standard for Adults QS13 and that all staff have access (where relevant) to specialist training including the QCF Level 3 Award in Awareness in End of Life Care which will:-

- Support the development of an open culture and awareness towards death and dying
- Facilitate collaborative learning and promote a supportive, palliative approach to end of life care
- Ensure that practitioners have the skills and confidence to talk with all Service Users and relatives/ carers about end of life care and how to document these discussions
- Prepare practitioners clinically and raise their awareness of cultural and ethical considerations
- Assist in the identification of Service Users who may be approaching the final stages of life
- Ensure care evolves as a part of a systematic, multidisciplinary care pathway and optimise the quality of care providing a seamless approach
- Ensure that systems are in place to reduce the risk of Service Users being inappropriately admitted to hospital at the end of life.

5.23.20. Staff will be appropriately trained to manage the processes and procedures sensitively, to ensure Service Users are treated with dignity and respect and receive appropriate care and symptom relief.

5.23.21. Practitioners/ staff will require specific training for Service Users who are cognitively impaired or require complex care e.g. Dementia, Motor Neurone Disease or Learning Disabilities.

5.23.22. The Provider will keep up to date with current and new approaches to end of life care.

5.23.23. On-going supervision will be provided to staff to support them and to provide an opportunity to consider and reflect upon their own cultural beliefs, values and attitudes to death and dying and enable staff as a team to reflect on care and dying within the home. Wellbeing of staff will be considered, and bereavement counselling promoted.
Learning from and continuous quality improvement will be integrated into the home's communication strategy.

5.23.24. The Provider as a minimum will be able to demonstrate that they have a strategic

approach to managing end of life care with policies in place reflecting local and national guidance and education for staff.

5.23.25. The Provider will notify the Commissioner without delay about the death of a Service User and inform the Care Quality Commission.

5.23.26. The Mental Capacity Act 2005 guidance is to be followed.

5.23.27. When a Service User dies in the home where there is either an authorised Deprivation of Liberty Safeguard in place or an application submitted to the Local Authority, the Provider will comply with the relevant legislation and guidance. The current guidance can be found here:

http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2017/03/GUIDANCE-No16A-DEPRIVATION-OF-LIBERTY-SAFEGUARDS-3rd-APRIL-2017-ONWARDS.pdf

5.23.28. Information will be available for the Service User and their families in an accessible format.

5.24. **PERSON CENTRED OUTCOME 24**

Staff Recruitment and Retention

Staff employed are fit and competent to meet the health and welfare needs of Service Users.

5.24.1. The Provider will operate a robust staff recruitment and selection procedure, in line with CQC regulations, which takes all reasonable steps to ensure that all individuals employed, including volunteers, those appointed through an agency and workers from other countries, are in all respects appropriate persons to work with vulnerable people. This includes all individuals employed in the home including and not limited to maintenance, cleaning, personnel, kitchen and administrative staff. A written policy and procedure shall be in place to reflect this practice.

5.24.2. The Provider will adhere to all equal opportunities and wage legislations and will be expected to embrace the principles of equality and diversity.

5.24.3. The Providers' staff recruitment and selection procedure must include a Disclosure & Barring Service (DBS) check at the appropriate level in accordance with the Safeguarding Vulnerable Groups Act 2006 requirements.
Photographic evidence of the staff member will be included on file and checked against a passport, driving licence or photo ID.

5.24.4. Providers employing staff who are required to obtain permission to work in the United Kingdom either directly or through an agency must ensure that employees have received clearance to work, have the necessary permits and relevant documentation

available prior to employment; copies of which must be evidenced in their personal file for inspection and monitoring purposes.

5.24.5. When recruiting staff, the Provider shall ensure that at least two appropriate written references are taken up one of which must be from the individual's last employer and shall demonstrate the means by which the suitability of all staff has been assessed. Where the reference provided only gives dates of employment the Provider must be able to demonstrate that all attempts have been undertaken to ensure a safe system of recruitment. The Provider shall include documented evidence of telephone contact with previous employer.

5.24.6. Staff will go through a full recruitment process including completion of an application form which provides complete employment history and addresses any gaps in employment history.

5.24.7. Staff, including those whose first language is not English, must have the personal qualities and caring attitudes which enable them to relate well to Service Users and carers, as well as the required skills in spoken English, written literacy and numeracy to do the tasks required for caring for and supporting Service Users.

5.24.8. Contemporary evidence of professional registration/PIN number checks will be obtained for all qualified nursing staff employed and regularly reviewed.

5.24.9. Providers shall maintain a personnel file for every employee which evidences all required documentation for inspection and monitoring purposes. Such documentation will include evidence of a written record of interview to demonstrate the applicant’s suitability for the post.

5.24.10. Providers employing agency staff will obtain a staff profile prior to commencement of the employment. This will include photographic ID, relevant skills and competencies for the position, qualifications, professional registration and an up to date training record.

5.24.11. Providers employing volunteers in the home will ensure volunteers are fit and competent to meet the health and welfare needs of Service Users. This will include photographic ID, relevant skills and competencies for the position, professional registration and an up to date training record and a Disclosure & Barring Service (DBS) check at the appropriate level in accordance with the Safeguarding Vulnerable Groups Act 2006 requirements.

5.25. **PERSON CENTRED OUTCOME 25**

Staffing Levels and Workforce Planning

Service Users are supported to achieve their maximum life potential and care needs by the provision of the appropriate level of professional expertise and skill mix.

5.25.1. The Provider’s staffing levels will enable the Provider to meet all the service standard requirements as detailed in this specification, both day and night, with the right competency, skills and experience, and to build in flexibility and promote sustainability of the workforce

5.25.2. The Provider must be able to fully evidence the method used for determining staffing levels in the home, for example by utilising or developing a staff ratio to service user dependency tool.

5.25.3. Staffing levels must be based on the dependency needs of all the Service Users, will be reviewed on a regular basis and evidence made available to ensure and demonstrate that they reflect the changing needs of the Service Users.

5.25.4. Staff numbers and skill mix will be matched to all Service Users' needs and reflect a high quality of care provision.

5.25.5. In determining the level and frequency of professional nursing expertise and intervention required (in care homes with nursing) the Provider will demonstrate the following:-

- The level, frequency and quality of time and intervention provided by a registered nurse undertaking actual care delivery, including clinical/technical or therapeutic activities on the Service User's behalf, is enough to meet their assessed needs and provide the ongoing management of care interventions
- The level and frequency of supervisory skills required by a registered nurse for teaching, guiding, advising, supporting and monitoring both Service Users and staff is enough to meet the Service User's assessed needs and promote and maintain standards of care
- The Registered Nurse providing nursing care demonstrates the skills, knowledge, clinical judgement and expertise to accurately assess and manage the stability and predictability of the Service Users' health.

5.25.6. The Provider will have contingency plans–also included within the Provider's Business Continuity Plan/Policy - in place to cover staff absence, sickness, annual leave and succession planning and will provide to the Commissioner on request.

5.26. **PERSON CENTRED OUTCOME 26**

Staff Induction and Training/Education

Service Users are cared for and supported by professionally inducted, trained, and competent staff, utilising best practice and this will be reflected in the standard of care that they receive.

5.26.1. The Provider will ensure that there is a staff induction, training and development programme, which will meet core skills training standards and include dementia, end of life and person-centred care training, which can be accessed through Skills for Care's Education and Training Frameworks.
Where registered nurses are employed, NMC Code of Professional Conduct Practice Guidance will be followed. These expectations will be clearly included in written policies and procedures to reflect a commitment to a supportive working and learning environment.

5.26.2. The Provider will ensure that staff new to care enrol on the Care Certificate within twelve weeks of commencing employment. All existing staff will be able to demonstrate that they also meet the standards of the Care Certificate.

5.26.3. The Provider will ensure that all staff working within the home are fully trained and assessed as competent to meet the individual needs of Service Users including all mandatory training and specialist and clinical education.

5.26.4 The Provider will ensure training provided, both internally and externally, is of high quality and that content is appropriate and is evidence based to reflect up to date specialist and social care and clinical guidance.

5.26.5. The Provider will undertake a training needs analysis for all staff which is reviewed regularly and updated and formulated into staff personal development plans.

5.26.6. The Provider must have an appropriate and deliverable training matrix in place that clearly identifies and timetables training and development needs of all staff within the home.

5.26.7. The Provider will be able to demonstrate assessment of staff competency and performance management and documented evidence will be made available; this could be through observations, supervision and appraisal processes or feedback from staff, Service Users or relatives. Where identified or required, the Provider will provide learning and development opportunities.

5.26.8. The Provider will ensure that staff understanding of training given is checked regularly through observation and supervision, including discussion at staff meetings, ensuring knowledge is embedded so that staff are confident to apply learning in their areas of work and that opportunities are offered for staff suggestions and feedback on running of the home and Service User needs.

5.26.9. Where there are identified concerns related to social care practice or the clinical practice competencies of individual employees this will be effectively managed by the home with evidence of the provision of mentorship and supervision.

5.26.10. Staff in charge of the home unsupervised will have the appropriate level of clinical and management competencies.

5.26.11. Where a Provider employs a newly qualified registered nurse or registered manager, they will ensure that preceptorship/ mentorship is provided for the first six months in post.

5.26.12. Providers who support student nurse placements and nurses' registration and adaptation programmes will be able to provide evidence of accreditation with a participating University.

5.26.13. Providers supporting candidates undertaking Nursing Adaptation Programme placements will ensure appropriate mentoring and provision of the required period of protected learning in accordance with Nursing and Midwifery Council requirements.

5.26.14. Providers will have a system in place to confirm new employees have successfully completed induction competencies prior to completion of the probationary period.

5.26.15. Staff will not commence duties unsupervised until they have been assessed as competent for the role.

5.26.16. The Provider will be responsible for determining that the training provider is suitably qualified and that the content of the courses meets the requirements of Adult Social Care Services.

5.26.17. Learning undertaken by individuals prior to employment with the Provider shall not give automatic exemption to the training requirements.

5.26.18. Casual staff/trainees and student workers will be subject to the same requirements

of all permanent staff.

5.26.19. When booking or recruiting Agency Staff for the home, the Provider must ensure that individuals are suitably trained to meet the needs of the individual Service Users and ensure a full induction has been provided. The Provider must be able to demonstrate safe recruitment of agency in line with good practice guidance from the Lancashire Safeguarding Adults Board (LSAB).

5.27. **PERSON CENTRED OUTCOME 27**

Staff Supervision and Appraisal

Service Users are cared for by staff who are suitably and regularly supervised, monitored, supported and appraised and this will be reflected in the standard of care that they receive.

5.27.1. A written policy and procedure will be in place to support the Provider's practice regarding supervision and appraisal.

5.27.2. All staff will receive formal supervision, including clinical supervision, where appropriate, in accordance with the Provider's policy. Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised. Supervision and appraisal sessions will be documented.

5.27.3. Staff will receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained, and at least six times per year.

5.27.4. Supervision will be systematically used to guide the work of staff, to reflect upon their work practices and as a means of support for staff to facilitate good practice, and better outcomes for the Service Users they support. Casual staff including agency staff, trainees and student workers will receive proportionate supervision support and review.

5.27.5. Service Users are supported to contribute to the supervision of their care staff.

5.27.6. Supervision and appraisal sessions will be documented.

5.27.7. Clinical supervision will be a critical element in the provision of safe and accountable nursing practice and inextricably linked to professional development. It is an exchange between practising professionals to enable the development of professional skills. It is also an opportunity to reflect on practice and necessary to enable practitioners to establish, maintain and promote standards and innovations in practice in the best interest of Service Users.

5.27.8. Robust appraisal systems will be in place and all staff receive an annual appraisal/personal development review.

5.27.9. Supervisors will be trained and supported in their supervisor role.

5.27.10. Staff that require membership of a professional body in order to practice will provide evidence of continued registration as part of the appraisal process. Employees will support the requirements for the Nursing and Midwifery Council (NMC) Revalidation in their supervision and appraisal processes.

5.27.11. Poor performance or staff conduct is identified, challenged and managed and documentary evidence made available to demonstrate that appropriate support has been provided and action taken.

5.27.12. The Provider must make a referral to DBS where the required conditions are met, this applies even when a referral has also been made to a safeguarding team or professional regulator and following dismissal/resignation during any investigations. Current guidance can be found on https://www.gov.uk/guidance/making-barring-referrals-to-the-dbs

5.28. **PERSON CENTRED OUTCOME 28**

Management and Leadership
The service is led so that individual Service User outcomes are achieved and sustained for the whole time Service Users live within the home.

5.28.1. The Provider will take responsibility for the leadership through the Registered Manager as well as their own investment of finance, interest and time.

5.28.2. The philosophy within the service is person-centred and promotes the benefits of open, trusting and collaborative relationships between staff, Service Users and their social and professional networks.

5.28.3. The Provider shall ensure that the home is managed is such a way that it complies with all requirements under the Health and Social Care Act 2008 and the Care Quality Commission (Registration) Regulations 2010, or any amending legislation.

5.28.4. The Provider promotes a clear understanding of the organisations purpose, values and vision and encourages learning and innovation by rewarding reflection, creativity, flexibility and positive risk management.

5.28.5. A manager shall be appointed and registered with the Care Quality Commission or will have applied to be registered with the Care Quality Commission within three months of commencement of employment within the home.

5.28.6. The Manager clearly demonstrates up to date knowledge and skills, leadership, competence and experience to effectively manage the home on a daily basis and has a sound understanding of the requirements set out in the contract terms and conditions and Service Specification.

5.28.7. The Manager will have experience to the equivalent of, or qualification in, or be working towards QCF Level 5 Diploma in Leadership in Health and Social Care within three months of appointment and completed within two years.

5.28.8. The Provider and Manager will keep up to date with good practice guidance in quality and ensure that this is shared and acted on throughout the service, where appropriate reviewing policies and procedures in line with changes.

5.28.9. The Manager maintains and demonstrates personal and professional competence and credibility in line with current practice and will ensure they delegate appropriately with

clear lines of accountability.

5.28.10. The Manager is a self-directed role model, committed to practice development and improving the care of Service Users, providing formal support, coaching and mentoring of all staff.

5.28.11. The Manager will ensure that staff will work collaboratively as an effective team in a culture of openness, promoting mutual support and respect with an appreciation of each other's roles.

5.28.12. The Provider shall ensure the following are in place to effect the continuous and sustained delivery of the service: -

- Proactive and reactive support so that the manager can competently meet all requirements of the service
- Contingency arrangements that plan for potential failure or service interruption
- Business planning so that continuity of the service is ensured and to assure those who rely on the service that it will continue to be provided
- Adequate programme so that the fabric of the building, fixtures and fittings, decoration and furniture is maintained and in good order.

5.28.13. The Provider shall co-operate with the Commissioner in times where the contingency plans require a joint response to interruptions, including reasonable requests for information.

5.28.14. The Provider will ensure processes and procedures are in place that promote continuous improvement within the home, both proactively and reactively.

5.28.15. The Manager will ensure that Service User views are at the core of quality monitoring and assurance arrangements. Feedback is sought from Service Users, Families, Staff and Professionals and there is evidence that Service User's views and experiences are acted on to shape and improve the home and culture.

5.28.16 The Provider will inform the Commissioner when the Registered Manager post is made vacant or appointed to.

5.28.17 The Providers representatives, including the Proprietor, Directors, Senior Managers and Registered Manager are fit and competent to meet the health and welfare needs of Service Users.

5.29. **PERSON CENTRED OUTCOME 29**

Quality Assurance
Continuous quality improvement systems are in place to ensure the home is run in the best interests of Service Users, demonstrates the quality and consistency of information, measures Service User outcomes and ensures that risks to Service Users are minimised.

5.29.1. The Provider will have quality assurance and monitoring systems in place which:-

- Seek the views and experience of Service Users, relatives, friends and health and

social care professionals, incorporating community contacts: e.g. schools, faith visitors, friends, where possible.

- Enable realistic assessment of the services provided.
- Support evaluating and learning from current practice to drive continuous improvement and manage future performance.

5.29.2. All staff will be actively involved in the quality assurance and monitoring processes. Quality services will be recognised as a motivating force and staff will strive for continuous improvement and best practice.

5.29.3. Quality Assurance will demonstrate: -

- Measurable organisational improvement
- Training that provides staff with the skills and tools to analyse problems and working processes
- Staff who are empowered and supported to make positive changes (analysing dilemmas/problems and suggesting solutions)
- Positive attitudes and working relationships
- Continuous building on good practice
- Introduction of new procedures.

5.29.4. All Registered Nurses will participate in clinical audit and reviews of clinical care in accordance with Nursing and Midwifery Council guidance.

5.29.5. Providers will be required to assist Commissioners in evaluating the quality of effectiveness, not only of the care to the individual Service Users but also compliance with the Contract Agreement. This will be undertaken on a schedule and by means as defined by the Commissioner.

5.29.6. The Provider will have a robust governance and auditing process which encompasses the following audits on a regular basis in line with their organisational policy;

- Care records, care and support plans and record keeping
- Medicines management
- Training
- Falls
- Infection prevention and control, including health care acquired infections (HCAI's)
- Medical device management
- Nutritional screening and support
- Tissue viability and wound care practice
- Accidents, incidents and complaints (including safeguarding alerts)
- Hospital Admissions
- Call bell responses if such technical systems are in place.

5.29.7. Findings from audits, inspections, assessments and reviews are clearly documented, trends are analysed, and details of actions taken including the responsible person and timescales for completion are documented. This information is used to support continuous improvements within the service.

5.29.8. The Provider will have effective processes in place to ensure learning from

information such as safety incidents, near misses, investigation findings or feedback takes place to make sure action is taken to improve safety and quality across relevant parts of the service.

5.29.9. Staff and Service User and/or representatives' meetings will be used as a forum to identify, take stock and reflect on areas for improvement. Such forums demonstrate that the home will be committed to involving and encouraging others to be included and listened to in the day to day running of the home.

5.29.10. A variety of feedback systems will be used which are suitable for the Service User group. These will be recorded, analysed objectively and published. Examples include:

- Verbal
- Written
- Observational tools
- Symbols/pictures
- Built into activities
- Group
- One to one (enables safe disclosure)
- External evaluation e.g. citizen checker, or at least assessors that are not part of day to day services.

5.29.11. The Provider will have a governance framework where responsibility and accountability are understood at all levels of the Provider organisation to ensure governance arrangements are properly supported. The Registered manager is supported by board / trustees, the Provider and other Managers where appropriate to deliver high standards of care and drive continuous improvement.

5.30. **PERSON CENTRED OUTCOME 30**

Financial Procedures/Personal Finances
Service Users are safeguarded by the accounting and financial procedures of the home. Service Users decide how to spend their money in the knowledge that personal finances are safeguarded by robust controls and audit procedures in the home.

5.30.1. Service Users' personal allowances must not be included as part of the fees. The Service User will retain control of their own money except where they state that they do not wish, or lack capacity and safeguards are in place to protect the Service User.

5.30.2. Providers shall ensure that all staff that handle money on behalf of Service Users clearly understand the procedure for receipting and recording all transactions. All such transactions, and recording thereof, will be audited regularly by the nominated individual for the service and/or significant other associated with the service e.g. Proprietor/Director.

5.30.3. The Provider will ensure that all staff understand how the Service User's right to autonomy, choice, independence and fulfilment is maintained within the context of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards in relation to any financial management issues.

5.30.4 Service User monies and related financial items (e.g. bank cards, cheque books etc.)

will be kept in a place of safety e.g. a safe, by the Provider where requested by the service user.

5.30.5 The Provider will ensure a policy is in place regarding the personal finances of service users, and if any activity relating to Service Users finances is considered to be illegal appropriate bodies will be informed. Provider HR/Personnel codes of conduct will reflect this, and due process and protocol will be followed in respect of any such activity.

Appendix 1 Processing, Personal Data and Data Subjects

<table>
<tr><td>Subject matter of the processing</td><td>Processing personal data and special category personal data for the provision of residential care services to service users</td></tr>
<tr><td>Duration of the processing</td><td>As set out in the main body of the contract</td></tr>
<tr><td>Nature and purposes of the processing</td><td>Processing: the obtaining, recording or holding the information or data or carrying out any operation on the information or data, which include:
organisation, adaptation or alteration of the information or data,
retrieval, consultation or use of the information or data,
disclosure of the information or data by transmission, dissemination or otherwise making available, or
alignment, combination, blocking, erasure or destruction of the information or data.
Purpose:
to safely and effectively deliver the terms of The Contract and Specification,
statutory obligations
employment processing directly linked to service delivery
such other purposes as the Purchaser may notify to the Provider from time to time</td></tr>
<tr><td>Type of Personal Data</td><td>Health & Care Services ID
Given Names
Preferred Names
Gender
Marital Status
Address
Previous Address
Date of birth
NI number
NHS number
GP
Professional Involvement
Name, age, gender, contact of relationships
Name, age, gender, contact of dependants
Telephone number
Next of Kin
Legal representation
Disability
Languages
Ethnicity
Images
Health & Medical
Sexuality
Religion
Employment history
Advocates
Financial Agents
Emergency contacts
Power of Attorney
Advanced decisions
Authorised representative
Contextual information for care delivery
Personal preferences
DoLs information
Reviews
Safeguarding Adults meeting minutes
Multi Agency Review minutes
Contact details for people listed in this section
Allergies
Sensory Impairment</td></tr>
<tr><td>Categories of Data Subject</td><td>Service Users</td></tr>
<tr><td>Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data</td><td>As per The Contract</td></tr>
</table>

APPENDIX 2

1.0 Quality Improvement Planning (QPIP)

1.1. In line with the Care Act 2014, the Lancashire Safeguarding Adults Board (LSAB) member organisations have committed themselves to the prevention of abuse and neglect and the improvement in the quality of care delivered to adults with care and support needs.

1.2. Overall Purpose

The Lancashire Quality, Performance and Improvement Planning (QPIP) process is a confidential, planned and coordinated multiagency response designed to ensure that when issues are raised regarding a significant shortfall in the quality of care delivered by a registered care provider these are addressed.

The following factors will trigger consideration of a QPIP:

- Organisational abuse enquiries are ongoing or substantiated and no improvements, or limited improvements, have already been implemented by the provider.
- Where safeguarding enquiries have occurred within a care setting and wider concerns have been identified re the quality of care being provided.
- Concerns exist with organisational leadership and/or culture in which senior managers within the setting/organisation are implicated
- Significant breaches of the CQC's five essential standards of quality and safety resulting in special measures status
- Where there are high levels of complaints or safeguarding activity indicative of wider quality issues within the setting/organisation which are a cause for significant concern.
- Where compliance and contract monitoring reporting identify an ongoing failure to address actions identified in the LCC contract improvement plan.
- Where there is data via the quarterly quality returns to CSU – Contract Management Team indicate there may be risks to the health and clinical needs of the people who use the service.

The QPIP process is not a replacement for individual safeguarding alerts, referrals and enquiries. The QPIP process is not an emergency response. Operational safeguarding enquiry teams undertake individual safeguarding enquiries in accordance with the Care Act 2014 and the LSAB multiagency policy and procedures.

1.3 Terms of Reference

The QPIP process is a proactive and planned approach, and will review and monitor the implementation of a QPIP improvement plan which will be developed by the provider. The

provider's QPIP improvement plan is the bringing together in one document all the key areas of concern from a number of separate agencies. The purpose over a series of meetings is for professionals to support a provider to make improvements by:

- ❖ Supporting the provider to be responsible for developing a comprehensive QPIP improvement plan with indicative timescales and ownership of the action identified.
- ❖ Collating and assessing information/intelligence in relation to the concerns raised about the provider.
- ❖ Seeking assurance that the needs of service users are being met through the undertaking of individual resident reviews.
- ❖ Determining if a recommendation for a contract suspension for new resident admissions is required.
- ❖ Monitoring and reviewing progress against the QPIP improvement plan.
- ❖ Requesting further information to demonstrate improvements made and the way these will be sustained.

When considering whether or not a QPIP process might be triggered, consideration will be given to what benefit the QPIP process will bring in terms of supporting a provider to improve the overall quality of the service provided, therefore ensuring the safety of the people who use the service.

The involvement of providers in making improvements to address quality concerns is expected in line with contractual requirements. Their attendance and involvement in the QPIP meeting process is voluntary. Where a provider is to be offered the support of a QPIP process, the chairperson will contact the proprietor and/or the registered manager in advance of the first QPIP meeting to make arrangements.

2.0 Provider Support

Through the QPIP process providers will be supported in the following ways:

- ❖ Assistance to develop their QPIP improvement plan.
- ❖ Invited to regular meetings to feedback on the progress being made against their QPIP improvement plan.
- ❖ Receiving constructive and meaningful feedback and advice via audit or monitoring visits.
- ❖ Provided with the contact details for multiagency professionals and support services.
- ❖ Being made aware of best practice tools, resources and forums.
- ❖ Signposting to other organisations.

3.0 Appointment of Chair

The chairperson for a QPIP meeting will be agreed at the Radar. The chairperson may be from CCG or LCC. The nature of the concerns will assist in determining an appropriate chairperson. The chairperson for providers of Adult Mental Health Services will be from LCFT.

4.0 Membership

Provider Representation:

- Registered Manager
- Nominated individual and/or provider
- Other key representative supporting the improvement plan

Agency representation may include:

- LCC Safeguarding Quality Improvement Team
- LCC Safeguarding Enquiry Service
- CCG Safeguarding and/or Quality Lead
- Commissioning Support Unit (NHS) Contract Management Team
- LCC Contract Management
- CQC
- NHS Services
- Police
- A note taker will be in attendance

5.0 Roles and Responsibilities of Representatives

5.1 The Chair will make contact with the provider, provide the terms of reference and the offer of a pre-meeting discussion to explain the QPIP process.
5.2 Providers are invited to bring key representatives who are supporting them with the implementation of their improvement plan to QPIP meetings.
5.3 Agency representatives will be expected to provide the chairperson with a written summary of concerns prior to the initial QPIP meeting. This information must have been shared already with the provider and will be discussed during the meeting to feed into the provider QPIP improvement plan.
5.4 Requests for others to attend who have no direct involvement e.g. students for training purposes will be permitted to attend only with the agreement of the provider and chair.
5.5 The provider will update their QPIP improvement plan and submit it to the chair seven days in advance of the meeting.

6.0 Frequency of Meetings

6.1 Once the QPIP process has been initiated, the frequency of subsequent meetings will be agreed, based on the actions to be undertaken, and the progress made.
6.2 At each QPIP meeting a date will be arranged for the subsequent meeting.
6.3 Additional meetings can be arranged if information arises that is a cause for concern, and may impact on progress.
6.4 The QPIP process is time limited and should not exceed a maximum of six months. In exceptional circumstances this may be extended with the agreement of the County Panel. Progress will be reviewed at each QPIP meeting. Where there is concern with the progress of the QPIP improvement plan a referral to the County Panel may be required.
6.5 The QPIP process will conclude when the actions identified at the start of the process, detailed in the QPIP improvement plan, are completed and there is assurance that the safety and quality of service is in line with contractual standards.
6.6 The final QPIP meeting will confirm support services available and confirm routine contract monitoring arrangements

6.7 The QPIP process will not usually be offered within a 2 year period with the same proprietor, and repeated failure to maintain improvements will be referred to the County Panel.

7.0 Format of Meetings

7.1 A QPIP meeting can consist of up to 3 distinct parts:

- **Part i - Agency Representatives:** key summary and discussion about the agencies concerns
- **Part ii – Provider representatives join the meeting (If participating in the QPIP meeting process):** Information is shared with the provider, who will be asked to provide an update on their QPIP improvement plan.
- **Part iii -** As required for agency action.

7.2 Notes will be available for all QPIP meetings, and the outcome will be shared with the attendees and those who sent apologies.
7.3 Quality Improvement Planning (QPIP) will report to the County Panel.

8.0 Confidentiality

Members are expected to adhere to confidentiality/information sharing procedures as per LSAB safeguarding procedures. Only secure email will be utilised should it be necessary to share staff or service user information.

These terms of reference will be reviewed and updated in light of experience, learning and changes in legislation.

APPENDIX 3 - Monthly reporting criteria

See below for indicative Contract and Quality Monitoring System Questionnaire: