NHS
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Clinical Commissioning Group

Operating standards for Care Homes

July 2019

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OPERATING STANDARD
CONTENTS

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OPERATING STANDARD

Standard: Hydration Care	
Number: 1	
Author(s): Jessie Retallick	
Date: June 2019	**Review Date:** June 2020

Topic Overview

Dehydration is a state in which our bodies do not have enough water. NHS England (2015) defines dehydration as a relative deficiency of fluid that causes adverse effects on function and clinical outcome. Dehydration can be mild, moderate or severe.
Chronic dehydration occurs when there is an ongoing low intake of fluid, and not enough is being taken in to replace the fluid lost from the body. This is a common problem among older people. People living in care homes are at high risk dehydration.

Factors contributing to drinking less and the high risk of dehydration include a reduced sense of thirst, concerns about getting to the toilet and fear of incontinence, possible swallowing problems, reduced kidney function, reduced muscle mass and medications that may affect fluid balance (e.g., diuretics). Other risk factors include increased frailty, cognitive and physical decline and reliance on carers to prompt and support drinking and eating (Volkert *et al.,* 2018).

Acute dehydration may occur where there is a sudden unexpected loss of fluid, or fluid and salts, as a result of conditions such as acute onset diarrhoea and vomiting. Acute dehydration can rapidly require an increase in fluid, or fluid and salts, either orally or intravenously. Severe acute dehydration is a medical emergency requiring intravenous fluid replacement and close monitoring of blood chemistry.

Optimum hydration is achieved when an individual drinks enough fluid to replace their daily fluid loss and any unexpected losses, enabling the body to maintain healthy hydration levels to support physical and mental health and wellbeing. In addition it is when the correct level of personal, nursing or medical care has been provided and all efforts have been made to provide the necessary support to help & encourage an individual to drink, with dignity and compassion, reflecting the individual's personal choice (Hydrate in care homes, Wessex AHSN, 2015)

Nurses should be familiar with the recommendations outlined in the Francis report (2013), which highlights the need for proper records to be kept of the food and drink supplied and consumed by elderly patients. A fluid balance chart should be started for all patients who are acutely unwell or considered at risk of dehydration (Campbell, 2014).

Recommended daily oral fluid intake: There is no exact amount, but the current guidelines recommend females should aim to drink 1600ml per day and males 2000ml per day (ESPEN, (Volkert *et al.,* 2018).). Aim for 6-8 glasses of fluid per day. This should only be considered a guide

to support clinical judgement, individual needs and best interest. It can be challenging for older people to drink this amount, so consider **optimal hydration,** the best intake you can encourage and assist a person to achieve.

Poor health outcomes associated with avoidable dehydration:

- Urinary tract infections
- Dizziness and increased risks of falls and fractures
- Lethargy and general malaise
- Constipation
- Reduced appetite, malnutrition
- Reduced cognitive ability
- Unexplained sudden confusion (delirium)
- Chest infections and exacerbation of COPD
- Exacerbation diabetes and other long-term conditions
- Poor oral health
- Pressure ulcers
- Embolism
- Medication side effects
- Acute Kidney Injury
- Sepsis
- Increased stroke risk
- Increased mortality

Dehydration should always be considered as a cause for any of the following:

- Dry mouth, feeling thirsty
- Headache, poor concentration, unexpected confusion, increasing agitation (delirium)
- Constipation
- Feeling dizzy when standing up (postural hypotension)
- Lethargy, malaise, increasing sleepiness (this may indicate hypo-delirium)
- Noticeably drier inelastic skin (reduced skin turgor)
- Dark concentrated urine
- Reduced urine output

Commissioner requirements

The commissioner requires that all providers will ensure that they deliver high quality hydration care to all residents and follow current local and national guidance to prevent 'avoidable' dehydration caused by lack of fundamental (basic) care.
Measures to prevent or minimise risk of dehydration and early identification should form the basis of all routine daily hydration care.

Providers will

- Provide hydration care in accordance to current national guidelines and best practice
- Assess at point of contact the person's hydration care needs and risk of dehydration and regularly review throughout the person's stay
- Monitor how well a person is drinking and take appropriate action as required and if a person's needs change
- Document above findings in the individual's care plan and create an action plan to ensure all hydration care requirements are met and monitored. Regularly review and update the action plan according to need
- Be aware of the impact of external conditions on hydration, for example extremely warm weather, and adjust people's fluid intake accordingly
- Provide 24 hour access to water and other preferred drinks of choice (unless contrary to

best interest, e.g. if it is considered unsafe to leave the drink in reach or has a fluid restriction, document details in care plan)

- Offer a choice of drinks that takes account of people's individual preferences, allergies, special requirements and diverse needs
- Provide person centred care by including the individual and their family or carer when assessing, planning and monitoring drinks offered and overall hydration care
- People receiving care should always be given the correct level of support for swallow, assistance and encouragement to drink and eat with dignity and respect
- Respect a person's choice to decline a drink. When a person refuses to drink, document this, try to establish the reason why and take appropriate action as needed; whilst always respecting the person's dignity, choice and best interest
- Assess the person's ability to safely swallow fluids and follow local referral guidelines for referring to a speech and language therapist if there is a suspected swallowing problem (dysphagia)
- Ensure that those recommended thickened fluids for dysphagia receive the correct consistency as per IDDSI (International Dysphagia Diet Standardisation Initiative)
- Ensure all staff responsible for purchasing, preparing, serving or assisting with drinks understands what to do to meet the agreed action plan
- Ensure staff have the appropriate skills and competencies and receive regular training to provide safe hydration care within their individual scope of practice and safely assist and encourage a person to drink
- Ensure all clinical staff can recognise signs and symptoms associated with mild, moderate and severe acute dehydration (hypovolaemic shock) and know the appropriate actions to take and when to escalate
- Ensure appropriate drinking aids are available to support safety, independence and personal choice. If a person is given a drinking aid e.g. plastic cup, straw, spouted beaker their person-centred care plan should explain the rationale
- Nominate a link Hydration & Nutrition nurse and Hydration and Nutrition Champions to promote best practice
- Consider using a tool to assess risk of dehydration e.g. ROC Holistic Hydration Care Assessment Tool
- Ensure all residents have their mouth care needs assessed and receive support to meet their daily mouth care need and preferences. Ensure mouth care frequency is increased if residents' needs change, and they have access to a dental practitioner as required (NICE, 2016)

Quality indicators	
Staff receive relevant training	Ensure staff have the appropriate skills and competencies and receive regular training to provide safe hydration care within their individual scope of practice and safely assist and encourage a person to drink
Care plans	Details of hydration-related care are documented in the individual record for every person and these are reviewed regularly or if the person's needs change

Supporting Information:

British Dietetic Association (2012) The Nutrition and Hydration Digest: Improving outcomes through Food and Beverage Services; http://www.bda.uk.com/publications/NutritionHydrationDigest.pdf

Campbell N (2014) Recognising and preventing dehydration among patients. Nursing Times. 2018 November 12: Vol 110 No 46 https://www.nursingtimes.net/download?ac=1291901

Care Quality Commission (CQC) Regulation 14: Meeting nutritional and hydration needs http://www.cqc.org.uk/content/regulation-14-meeting-nutritional-and-hydration-needs

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: Stationery Office. tinyurl.com/HMSO-Francis2

Hydrate Toolkit, Improving hydration among older people in care homes and community (2016) Developed through collaboration between Kent Surrey and Sussex Academic Health Science Network, Wessex Academic Health Science Network and NE Hants and Farnham CCG. https://wessexahsn.org.uk/img/projects/Hydration%20toolkit%20V1.pdf

International Dysphagia Diet Standardisation Initiative (IDDSI) Framework, https://iddsi.org/
NHS England (2015) Guidance – Commissioning Excellent Nutrition and Hydration 2015 – 2018 https://www.england.nhs.uk/wp-content/uploads/2015/10/nut-hyd-guid.pdf

NHS England (2018) Enhanced Health in Care Homes learning guide for Hydration and Nutrition updated version May 2018

NICE (2010) Clinical Guideline 103 Delirium; Diagnosis, prevention and management http://www.nice.org.uk/nicemedia/live/13060/49909/49909.pdf

NICE (2013) Acute Kidney Injury: Prevention, Detection and Management https://www.nice.org.uk/guidance/cg169/resources/acute-kidney-injury-prevention-detection-and-management-35109700165573

NICE (2016) NICE Guideline 48 'Oral health for adults in care homes' https://www.nice.org.uk/guidance/ng48
Think Kidneys (2016) Acute Kidney Injury and Care Homes https://www.thinkkidneys.nhs.uk/aki/wp-content/uploads/sites/2/2016/02/AKI-and-Care-Homes-Presentation.pdf

SCIE (2009) ADULTS' SERVICES SCIE GUIDE 15 – Dignity in Care; Nutritional care and hydration http://www.scie.org.uk/publications/guides/guide15/files/guide15-nutrition.pdf

Volkert et al (2018) ESPEN guideline on clinical nutrition and hydration in geriatrics. Clin Nutr. 2018 Jun 18. pii: S0261-5614(18)30210-3. doi: 10.1016/j.clnu.2018.05.024.

https://www.ncbi.nlm.nih.gov/pubmed/30005900

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OPERATING STANDARD

Procedure: Nutrition	
Number: 2	
Author(S): Jessie Retallick	
Date: June 2019	**Review Date:** June 2020

Overview

Appropriate and adequate nutritional care is vital to overall health. Malnutrition occurs when a person has a deficiency of energy, protein or other nutrients. This may be due to reduced food intake or problems absorbing nutrients, meaning that a person does not receive enough to meet their requirements.

Malnutrition is both a cause and a consequence of ill-health and can be life threatening. Malnutrition increases the risk of the following:

- Reduced ability to fight infection
- Pressure ulcers and delayed wound healing
- Impaired function of heart and lungs
- Inactivity, decreased muscle strength and increased risk of falls
- Tiredness, depression, apathy
- Increased risk of dehydration (a balanced diet provides 20% of daily fluid intake)

In the UK, 1 in 3 people admitted into care homes and hospitals are already malnourished or at risk of malnutrition (BAPEN 2012). People over the age of 65 are at higher risk of malnutrition due to factors such as reduced mobility, long term health problems, dementia, side-effects of medications, reduced sense of taste and smell, socio - economic pressures, mental health issues, a reduced ability or dependency on others to prepare food or to assist with eating and drinking.

Malnutrition is under-recognised and under-treated. Malnutrition can be difficult to recognise, especially if a person is overweight or obese to start with. It is important that all residents are screened for malnutrition regularly to identify and treat malnutrition risk early.

Early signs of malnutrition (undernutrition) and weight loss may include:

- Clothes, belts, jewellery and dentures become looser over a period of time
- Reduced appetite or reduced interest in food and drinks
- Feeling more tired, lethargic or weaker than normal
- Feeling depressed
- Unable to keep warm enough
- More prone to illnesses e.g. common cold, viruses
- Delayed wound healing

The 5 step ‘Malnutrition Universal Screening Tool’ (MUST) provides a standardised

screening tool to identify those people at risk of malnutrition (NICE 2006; BAPEN 2011). It is important that malnutrition is identified and treated early.

As a result of MUST screening an appropriate nutritional care plan based on local guidance should be developed for each individual. The first-line treatment for malnutrition risk is to provide nutrition support using 'Food First', food fortification and homemade fortified drinks, adapted to the individual's needs. NICE guideline CG32 states that care homes should provide adequate quantities of good quality food if the use of unnecessary nutrition support is to be avoided. Onward referral may be required for those requiring alternative forms of nutrition support (NICE, 2006).

Commissioner requirements

The commissioner expects that all providers will assess the nutritional needs of all residents, including screening for malnutrition, and that all residents have enough to eat and drink to meet their individual nutrition and hydration needs and receive the support they need to do so. The commissioner expects providers to deliver individualised high quality nutritional care to all residents with dignity and respect, in accordance with national standards and delivering best practice at all times.

Providers will

- Ensure all residents have enough to eat and drink to meet their individual nutrition and hydration needs
- Provide a 24/7 food and drinks service that delivers a nutritionally balanced diet to meet the individual needs of the people in their care
- Screen all people on admission using MUST: 'Malnutrition Universal Screening Tool' to identify malnutrition risk (NICE, 2006) and screen monthly thereafter, or more frequently if there is a clinical need
- Assess, plan and set goals to adapt nutritional intake in response to MUST score, based on local guidance (or Step 5 of MUST)
- Ensure appropriate use of first-line interventions to address malnutrition risk, i.e. 'Food First', food fortification and homemade fortified drinks, individualised based on resident's needs, unless there are clinical reasons for alternative forms of nutrition support, e.g. Oral Nutritional Supplements (ONS), enteral feeding
- Request medical review and onward referral if unexpected weight loss remains a concern
- Ensure all staff responsible for carrying out nutritional screening receive adequate training and have the appropriate resources; this includes access to weighing scales that are regularly calibrated and a stadiometer (height stick) if possible.
- Offer a choice of food and drink that takes account of people's individual preferences, special dietary requirements, allergies and diverse needs and provide alternative choice if a person does not like the food offered
- Provide sufficient amounts of food, at the right temperature and appropriate portion sizes to meet residents nutritional needs

- Provide person centred care by including the individual person and/or their family or carer when assessing, planning and monitoring food and drinks services.
- Document all above findings in the individual's nutritional care plan to ensure all nutrition and hydration care requirements are met and monitored and the action plan is regularly reviewed and updated according to need.
- Provide adaptive equipment where appropriate to support optimum independence with eating and drinking
- Respect a person's choice to decline food. When a person refuses to eat, document this, try to establish the reason why and take appropriate action as needed; whilst always respecting the person's dignity, choice and best interest
- Provide clear verbal and written communication to all staff who are responsible for purchasing, preparing, cooking, serving or assisting with food and drinks to ensure they understand what to do to meet residents nutritional care plans
- Recommend referral to a dietitian for individuals with complex nutritional needs, those at risk of malnutrition and continuing to decline despite first-line advice, following local referral guidelines
- Recommend onward referral and multi-disciplinary team input for those potentially requiring assessment for alternative forms of nutrition support, e.g. enteral feeding
- Consider the person's ability to safely swallow foods and follow local guidelines for referring to a speech and language therapist if there is a suspected swallowing problem (dysphagia)
- Ensure that those recommended a texture modified diet for dysphagia receive the correct consistency as per IDDSI (International Dysphagia Diet Standardisation Initiative)
- Ensure they allow individuals to choose when, where and with whom they want to eat, providing a service and environment conducive to people enjoying their meals; having a communal dining room available
- Ensure all residents have their mouth care needs assessed and receive support to meet their daily mouth care need and preferences. Ensure mouth care frequency is increased if residents' needs change, and they have access to a dental practitioner as required (NICE, 2016)
- Nominate a link nurse and champions for the promotion of nutrition and hydration
- Consider using a tool to identify the assistance and encouragement a person needs to eat and drink, e.g. 'Reliance On a Carer' (ROC) to Eat (as part of the Holistic Hydration Care Assessment Tool)

Quality indicators	
Nutrition	All residents are regularly screened using the MUST tool (Malnutrition Universal Screening Tool) to identify risk of malnutrition
Staff receive relevant	Ensure staff have the appropriate skills and competencies

training	and receive regular training to provide safe nutritional care within their individual scope of practice
Care plans	Details of nutritional care are documented in the individual record for every person and these are reviewed regularly or if the person's needs change

Supporting information:

BAPEN (2011) http://www.bapen.org.uk/pdfs/must/must_full.pdf

BAPEN (2012) Nutritional Screening Survey in the UK and Republic of Ireland 2010

British Dietetic Association (2012) The Nutrition and Hydration Digest: Improving outcomes through Food and Beverage Services
http://www.bda.uk.com/publications/NutritionHydrationDigest.pdf

Care Quality Commission (CQC) Regulation 14: Meeting nutritional and hydration needs
http://www.cqc.org.uk/content/regulation-14-meeting-nutritional-and-hydration-needs

International Dysphagia Diet Standardisation Initiative (IDDSI) Complete Framework (2017)
http://iddsi.org/Documents/IDDSIFramework-CompleteFramework.pdf

Malnutrition Task Force (2017)
http://www.malnutritiontaskforce.org.uk/wp-content/uploads/2017/10/AW-5625-Age-UK-MTF_Report.pdf

NHS England (2015) Guidance – Commissioning Excellent Nutrition and Hydration 2015 – 2018
https://www.england.nhs.uk/wp-content/uploads/2015/10/nut-hyd-guid.pdf

NICE (2016) NICE Guideline 48 'Oral health for adults in care homes'
https://www.nice.org.uk/guidance/ng48

NICE (2006) Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition (CG32)
http://www.nice.org.uk/nicemedia/live/10978/29981/29981.pdf

NICE 2012 Quality Statement https://www.nice.org.uk/guidance/qs24

NMC Code (2015)
https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

Reliance On a Carer (ROC) Holistic Hydration Care Assessment Tool
https://hydrationcareconsultancy.co.uk/

Volkert et al (2018) ESPEN guideline on clinical nutrition and hydration in geriatrics. Clin Nutr. 2018 Jun 18. pii: S0261-5614(18)30210-3. doi: 10.1016/j.clnu.2018.05.024. [Epub ahead of print]

https://www.ncbi.nlm.nih.gov/pubmed/30005900

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OPERATING STANDARD

Procedure: Tissue Viability	
Number: 3	
Author(S): Nicci Aylward-Wotton	
Date: May 2019	**Review Date:** May 2020

Topic overview

Care homes provide care for an increasing number of elderly residents at varying stages of dependence. The level of which appears to be increasing (Blood 2010). In view of this, the risks to residents of developing pressure ulcers increases. Equally the scale of knowledge required by carers in care homes must increase in order to provide a high standard of physical care and therefore prevent pressure ulcers. It is important that care home residents do not become compromised with regards to wound care needs.

Pressure ulcers affect 20% of people in acute care, 30% of people in the community and 20% of people in nursing and residential homes (Clark et al, 2004). The consequences of pressure ulcers should not be underestimated. Not least in terms of financial cost to the NHS (2.3–3.1 billion a year (Posnett and Franks, 2007)) but more importantly to the physical and psychological impact on the individuals that are involved. The potential to die from a severe pressure ulcer is also a very real prospect. In 2010, 218 people died in hospitals and care homes in England and Wales where the cause of death was recorded as bedsores (Donnelly and Clayton 2012). In addition, 25343 died of other causes while suffering from a pressure ulcer (Donnelly and Clayton 2012). Considering that in most cases pressure ulcers are preventable most of these deaths are avoidable occurrences (Institute for Healthcare Improvement, 2011). In some cases health professionals and/or organisations are being held accountable if a person develops a pressure ulcer while in their care (Guy, 2010). This is in recognition of a failure to provide sufficient care resulting in neglect and abuse (Clarkson 2007). With respect to the 25343 who died with the addition of a pressure ulcer this raises the question of prevention strategies and standards of care of patients in the latter stage of their lives have received.

Commissioner requirements

The commissioner expects that all providers will deliver high quality tissue viability care to all patients and follow current national guidance regarding pressure ulcer prevention. Care home providers are expected to be able to provide general wound care including the treatment of pressure ulcers and leg ulcer management.

Providers will:
• Assess and monitor all residents to determine the risk of developing pressure ulcers via a risk assessment on admission to their care and on a regular basis depending on their level of mobility and risk to reduce the risk of developing pressure ulcers. • Ensure that care staff undertakes a SKIN assessment and act on issues identified and provide a patient specific care plan. • Use skin bundles in collaboration with the local Tissue Viability Service. • Ensure that their staff attends relevant training and education sessions in order to identify and assess residents at high risk of developing pressure ulcers. This training to include the MUST, continence management and frailty score. • Ensure that a clinical assessment and treatment plan will precede the provision of any equipment or treatment. • Ensure every effort is taken to facilitate easy access to pressure relieving equipment. • Develop excellence in preventative strategies, including appropriate equipment for the prevention of pressure ulcers. • Have a link/resource nurse for Tissue Viability and attend the study days provided by Tissue Viability team on a bi-monthly basis • Carry out skin care regimes in line with current Tissue Viability advice. • Implement the treatment plan. • Refer all grade 3 and 4 pressure ulcers to Tissue Viability, and report to CQC and NHS Kernow Clinical Governance Lead. • All patients with leg ulcers should have a leg ulcer assessment and have leg ulcer treatment commenced depending on the results of this. • All nurses applying compression treatment must attend leg ulcer training and be assessed as competent to apply safely. • All wounds should be assessed and evaluated using a recognised assessment and evaluation template. • All dressings should be applied in line with the Cornwall Joint Formulary.

Quality indicators	
Tissue Viability	Residents assessed at high risk of developing pressure ulcers have a patient specific care plan that outlines preventative strategies. Staff attend pressure ulcer training and wound care training at induction. All care homes have Tissue Viability Link nurses and attend study days provided by Tissue Viability team.

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OPERATING STANDARD

Standard: Continence Care	
Number: 4	
Author(S): Sharon Eustice	
Date: May 2019	**Review Date:** May 2020

Topic overview

Urinary incontinence is one of the leading causes for admission into Care Homes. The scope of the problem is significant, the costs are high and there is no convincing evidence of lasting change for sufferers of this problem in Care Homes. However, incontinence is very treatable. Prevalence studies have indicated an association between ageing and urinary incontinence. Estimates of prevalence range between 31% to over 70% in both community and institutional settings. Reasons for developing standards include:

- National prevalence figures suggest that 2 out of every 3 people who live in Care Homes are incontinent.
- Residents who have been identified as incontinent should have access to assessment, treatment and management of their problem as per national and local guidelines.
- Local surveys suggest that there is considerable variation in the management of incontinence in Care Homes.
- Care Homes which state they are able to provide services for people with incontinence should be able to demonstrate this.
- The need for education and training of staff in the assessment and management of incontinence, particularly where there are long-term conditions such as dementia, stroke, diabetes or frailty.
- The preservation of privacy and dignity during continence care is an essential feature of care delivery.

Commissioner requirements

The commissioner expects that all providers will ensure that they deliver high quality continence care to all patients and follow current local and national guidance; and that bladder or bowel continence problems are identified and reversible causes treated, with the aim to restore continence by implementing assessment and therapeutic treatment.

Providers will

- Screen the resident for bladder and bowel continence problems by asking a trigger question (e.g. are you bothered by your bladder or bowel?).
- Identify and treat reversible causes of bladder and bowel dysfunction, with the aim to restore continence by implementing assessment and therapeutic

treatment.

- Implement clinical assessment and a treatment plan, which will precede the provision of absorbent hygiene products.
- Use indwelling urinary catheters only as a last resort with the aim of removing the catheter as soon as possible.
- Participate in education to identify and assess residents with bladder and bowel symptoms.
- Nominate a link/resource nurse for the promotion of continence.
- Use care pathways in collaboration with the local Bladder and Bowel Specialist Service.
- Facilitate easy access to toilet facilities.

Quality indicators	
Continence Care	All residents are asked on admission if they are bothered by their bladder or bowel and a clinical assessment is undertaken for those who have a continence problem.

Supporting Information:

Bladder and Bowel UK (2016)
www.bladderandboweluk.co.uk

BGS (2016) Guidance on commissioning and providing healthcare services across the UK. British Geriatric Society https://britishgeriatricssociety.wordpress.com/tag/guidance-on-commissioning-and-providing-healthcare-services-across-the-uk-effective-healthcare-for-older-people-living-in-care-homes/
https://www.bgs.org.uk/resources/continence-care-in-residential-and-nursing-homes

Expert Group on LUTS (2014) Who cares? Uncovering the incontinence taboo in social care. Astellas Pharma Ltd

Fader M et al (2016) Continence Product Provision: Meeting patients' fundamental care needs. Policy Brief. University of Southampton

NICE (2007) Faecal incontinence in adults: management Clinical Guidance 49. The National Institute for Health and Care Excellence

NICE (2008) Irritable bowel syndrome in adults: diagnosis and management Clinical Guidance 61. The National Institute for Health and Care Excellence

NICE (2010) Lower urinary tract symptoms in men Clinical Guidance 97. The National Institute for Health and Care Excellence

NICE (2010) Stroke in adults Quality Standard 2. The National Institute for Health and Care Excellence

NICE (2012) Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline 139. The National Institute for Health and Care Excellence

NICE (2012) Urinary incontinence in neurological disease: assessment and management Clinical Guidance 148. The National Institute for Health and Care Excellence

NICE (2013) Lower urinary tract symptoms in men Quality Standard 45. The National Institute for Health and Care Excellence

NICE (2013) Urinary incontinence: the management of urinary incontinence in women Clinical Guidance 171. The National Institute for Health and Care Excellence

NICE (2014) Faecal incontinence in adults Quality Standard 54. The National Institute for Health and Care Excellence

NICE (2015) Urinary incontinence in women Quality Standard 77. The National Institute for Health and Care Excellence

NICE (2015) Urinary tract infections in adults Quality Standard 90. The National Institute for Health and Care Excellence

NICE (2016) Irritable bowel syndrome in adults Quality Standard 114. The National Institute for Health and Care Excellence

NHSE (2018) Excellence in continence care: Practical guidance for commissioners, providers, health and social care staff and information for the public. National Health Service England https://www.england.nhs.uk/wp-content/uploads/2018/07/excellence-in-continence-care.pdf

RCP (2010) Royal College of Physicians/HQIP, National audit of continence care: combined organisational and clinical report, September 2010 https://www.rcplondon.ac.uk/projects/outputs/national-audit-continence-care-nacc

Shaw C and Wagg A (2017) Urinary incontinence in older adults. Medicine in Older Adults Volume 45, Issue 1, Pages 23–27

SIGN (2006) Management of Bacterial Urinary Tract Infection Guideline 88. Scottish Intercollegiate Guideline Network. http://www.sign.ac.uk/pdf/sign88.pdf

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OPERATING STANDARD

Procedure: Infection Prevention	
Number: 5	
Author(S): Lisa Johnson	
Date: June 19	**Review Date:** May 2020

Topic overview

The steps taken in Care Homes to protect residents and staff from infection represent an important element in the quality of care, particularly as some infections have the capacity to spread within environments where susceptible people share eating and living accommodation. It is also important to be aware of the possibility of infection in residents and for care workers to identify these promptly.

Commissioner requirements

The commissioner expects that providers will comply with the requirements set out in the documents indicated at the end of this Operating Standard and be able to provide evidence to that effect. In doing so residents and staff will be protected from avoidable infections.

Providers will

All good practice interventions are encompassed within Hygiene Code compliance. The following list reflects best practice which could be assessed by observation or questioning:

- All staff are trained to understand infection prevention responsibilities of their individual role.
- Previous infection and risk of infection should be assessed and documented for each resident.
- Staff are aware of Sepsis and trained to recognise signs and escalate.
- Care plans should reflect infection status and specify best practice relating to any invasive devices.
- Staff providing personal care must be bare below the elbows, have short nails without nail varnish and not wear any rings other than a plain band.
- Work-wear must be clean on each shift and of material that can withstand high temperature laundering.
- Hand hygiene performed according to the World Health Organisation (WHO) '5 moments'[1].
- Adequate protective clothing must be available and used appropriately according to risk of procedure.
- Equipment and environment are cleaned/disinfected according to policy.
- Medical devices must be stored to avoid contamination.

[1] http://www.who.int/gpsc/5may/tools/workplace_reminders/en/

- Laundry is handled, stored and cleaned appropriately to minimise contamination of staff, equipment and environment.
- Sharps are safely disposed of in correct containers.
- Waste is correctly segregated in colour coded bags and stored in a locked area before collection.
- Laboratory specimens are collected appropriately, (using aseptic technique where required) stored safely before collection.
- Specimen results are recorded to detect patterns, clusters or outbreaks.
- Antimicrobial medication is reviewed regularly and complies with local guidance.
- Antibiotic usage can be reduced by use UTI management tool.
- Annual influenza vaccination is encouraged and recorded for both residents and staff.

Quality indicators

Quality requirement	Method of measurement
Staff are seen to be bare below the elbows	Observation
Equipment is visibly clean and free from dust.	Observation
A named lead for infection prevention is identified.	Documentation and evidence of activity.
Staff are aware of Sepsis signs and escalation.	Training records

The Care Quality Commission (CQC)
http://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf page 43 (12(2)h)

Providers are referred to the hygiene code for guidance.
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance
A common source of information on the prevention and control of infection in Care Homes was published in February 2013.
https://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published

NICE guidance
http://www.nice.org.uk/guidance/qs61/chapter/list-of-quality-statements
https://www.nice.org.uk/guidance/cg139/chapter/1-Guidance
Link to app approved by local DIPC group.
http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/healthcare-associated-infections/training-resources/preventing-infection-in-care-@-home.aspx
NHS Kernow IPAC web page
https://www.kernowccg.nhs.uk/your-health/infection-prevention-and-control/care-homes/
Sepsis Training
https://www.e-lfh.org.uk/programmes/sepsis/

Care Home UTI Management Tool for persons >65

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Care home suspects a resident has a UTI and has ruled out other sources of infection (see reference sheet)

Patient:……
DOB:……
Nursing Home:……
Date:……

NEW ONSET Symptoms	What does this mean?	Tick if present
Dysuria	Pain on urinating	
Urgency	Need to pass urine urgently/new incontinence	
Frequency	Need to urinate more often than usual	
Suprapubic tenderness	Pain in lower tummy/above pubic area	
Haematuria	Blood in urine	
Polyuria	Passing bigger volumes of urine than usual	
Loin pain	Lower back pain	
Delirium	Confusion - new onset or worsening of pre-existing	

Less than 2 symptoms (or 1 if urinary catheter)- **UTI <u>UNLIKELY</u>**:
-Observe,
-Manage symptoms
-Encourage fluid intake

2 or more symptoms- **UTI <u>LIKELY</u>**
Please record vital signs

Vital signs		Result	
Temperature			
Heart rate			
Respiratory rate			
Blood Glucose			Diabetic? Y / N
Bloods Taken?			wcc: CRP
Catheter	Temp Perm		

Action Plan	Done
Phone GP: state symptoms and vital signs	
Collect Mid Stream Urine specimen and send to microbiology lab	
Fax this tool to GP	
Name/Sign/designation	Date/ Time

<u>GP Management Decision</u>
Prescribing guidance at https://www.eclipsesolutions.org/Cornwall/info.aspx?chapterid=9

- ❑ ***Face to face review by GP undertaken?***

(If YES then GP to complete below. If NO then carer to complete based on conversation with GP)

<u>DIAGNOSIS</u>

- ❑ Lower UTI
- ❑ Pyelonephritis
- ❑ Currently not clear. Await MSU & monitor patients symptoms
- ❑ Other ……

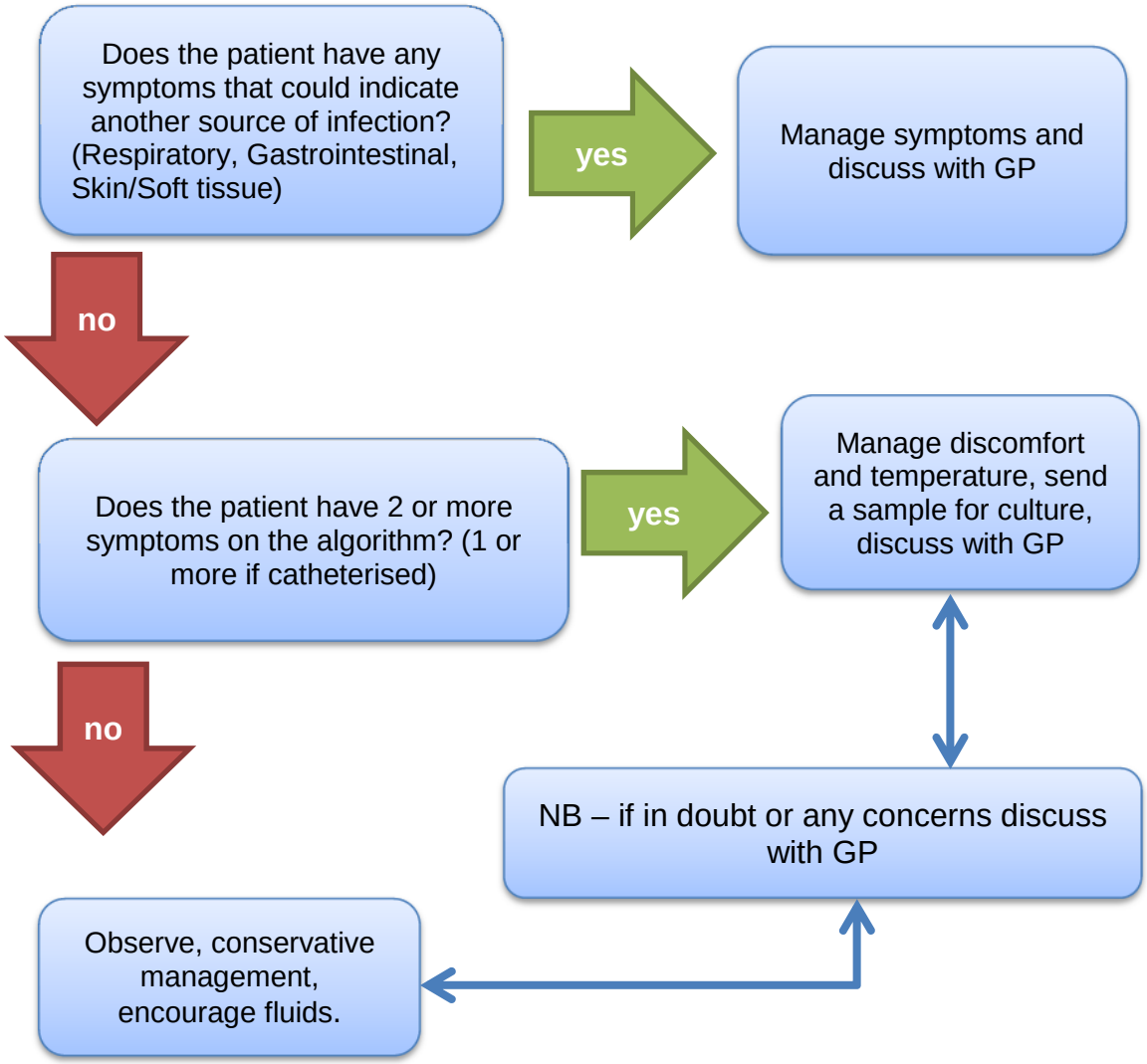
<u>PLAN</u> (tick all that apply)

- ❑ Review in 24 hours
- ❑ Mid Stream Urine specimen (MSU)
- ❑ Antibiotics prescribed & details……
- ❑ Other ……

Sign & print……
Date……
Designation……

Management Pathway for when care home suspects UTI

(simplified from Sign 88)



URINE CULTURE IN WOMEN AND MEN > 65 YEARS

Only send urine for **culture if two or more signs of infection**, especially dysuria, fever > 38 ^{o} or new incontinence.
Do not treat asymptomatic bacteriuria in the elderly as it is very common.

Treating does not reduce mortality or prevent symptomatic episodes, but increases side effects & antibiotic resistance.

URINE CULTURE IN WOMEN AND MEN WITH CATHETERS

Do not treat asymptomatic bacteriuria in those with indwelling catheters, as bacteriuria is very common and antibiotics increase side effects and antibiotic resistance.
Treatment does not reduce mortality or prevent symptomatic episodes, but increase side effects & antibiotic resistance.
Only send urine for **culture in catheterised if features of systemic infection**. However, always:

- Exclude other sources of infection.
- Check that the catheter drains correctly and is not blocked.
- Consider need for continued catheterisation.
- If the **catheter** has been in place for **more than 7 days, consider changing** it before/when starting antibiotic treatment.

Do not give antibiotic prophylaxis for catheter changes unless history of symptomatic UTIs due to catheter change.

Face to face review between patient and prescribing clinicians is NICE Quality Standard when diagnosing a UTI (UTI's in adults QS90, June 2015)

Public Heath England – treatment guidance September 17

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643046/Management_and_treatment_of_common_infections.pdf

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Procedure: Dementia Care	
Number: 6	
Author(S): Jodie Ley	
Date: May 2019	**Review Date:** June 2020

Topic overview

The Department of Health (2015) describe the term 'dementia' as a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. In 2015 data published by the Alzheimer's Society, suggests there are 850,000 people living with dementia in the UK, 84,413 of these people live in the South West and approximately 33% of these people reside within residential care.

There are approximately 416,000 people living in care homes in the UK (Laing and Buisson survey 2016). This is 4% of the population aged 65 years and over, rising to 16% of those aged 85 or more. Cornwall currently has an approximate population of 536,000 (Cornwall Council, 2011) 129,100 are aged over 65years, 24% of our population. 4104 (Cornwall Council 2015) people live in a care home setting. Cornwall having 5478 care home beds in the County. There is a high prevalence of cognitive impairment and polypharmacy (NHS, 2016). This affects how care can, and should be delivered. In contrast, 40% of people over the age of 65 occupying a hospital bed will be living with dementia (Alzheimer's Society, 2014). Residents of Care homes have high levels of complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty. Furthermore these vulnerable individuals also have high rates of both primary care consultation and hospital admission. Learning from the work of the Gateshead Care home vanguard we know that 80% of people seen in this site area were living with a mental health issue of some kind.
People living with dementia can experience a variety of diverse symptoms, which may provide challenges during the delivery of care. For this reason it is it is essential that care homes have the knowledge and skills of physical disability or access to those that can support them to meet the needs of such illness. Furthermore co-morbidities can add to the challenge of empowering people with dementia and delivering excellent person-centred care as described by Kitwood (1995).

In 2009 the Government committed to making dementia a national priority with the publishing of The Dementia Strategy, and revised Dementia strategy in 2013. More recently we have seen the government's commitment with the development of the Prime Minsters Challenge on Dementia 2020.

The Dementia Strategy (2013) advocates the importance of care settings being responsive to individual needs, providing people with choice, the ability to make decisions about their care and providing personalised care. Recommendations state that settings should formulate non-pharmacological interventions, for what they term

behavioural disorders in dementia, to avoid using medical alternatives, such as anti-psychotic medication. Suggesting people with dementia have access to individual purposeful activities, rather than general entertainment.
A continual drive to improve the quality of care received by people living with dementia is maintained by the development of the National Institute for Health and Care Excellence Quality Standards (NICE, 2013). Providing standards to ensure health and social care providers provide measurable quality improvements within a particular area of health or care.
The care provided in Care Homes is underpinned by the basic requirement of knowledge based care through quality training in this area, also a requirement of The Dementia Competency Framework DoH (2011); furthermore the Care Quality Commission sets out basic standards that are expected within care environments and monitors homes.

With such legislation and guidelines in place to support people living with Dementia and the care environment they are in, it is vital that a sound working knowledge underpinned by theory be demonstrated in the area of Dementia Care.

Commissioner requirements

In order to achieve Gold Standard quality of care:

- A workforce equipped with a comprehensive working understanding of the often complex needs of those living with Dementia together with an awareness of how to interoperate a person's bio-psychosocial experiences of living with dementia and how these can impact on both mental and physical wellbeing.
- To provide person centred, individualised care that reflects the ever changing and often challenging needs of the individual through robust risk and care planning.
- To maintain the rights of individuals through having an up to date working knowledge of The Mental Capacity Act (2005) to include Deprivation of liberty Safeguards (DoL's), The Mental Health Act (2007) and how these issues may impact on care.
- To provide a professional service within a safe and happy environment that is conducive in promoting the wellbeing and meeting the needs of the individual.

Providers will
• Ensure staff are trained and clearly understand Dementia. This would include the different type groups of dementia. • Staff should be supported via training and shared knowledge to understand how to provide person centred, individualised care planning. James (2007) describes model of this well. But staff are expected to us a featuring a bio-psychosocial approach to all residents in their care, have a clear knowledge of what each of these areas of assessment would require. • Ensure staff have a proactive approach to medication management whilst being able to identify promptly when to seek advice. Liaising with their community pharmacist to conduct regular reviews of all residents' medication, considering polypharmacy. This maybe in conjunction with other healthcare professionals such as the DLN's or community matron. • Demonstrate a strong working relationship with relatives and carers, GP's and secondary services as necessary. • To proactively encourage early diagnosis of dementia and ensure all those suspected of living with dementia are supported to gain diagnosis, via DLN or GP, community pharmacist. • Have a sound working knowledge of The Mental Capacity Act, some knowledge of the Mental Health Act and a robust understanding of the implications of Deprivation of liberty Safeguards. • Provide individualised meaningful activities, advocating a person's personal interests. • Staff should have a good understanding of a person as an individual and what unmet needs in terms of behaviours that challenge. • Tools have been devised in Cornwall to assist in the education of staff and support them within their work in Care Homes as follows: - Dementia End of Life Pathway (2012) - AMP (Asses, Monitor, Prevent) - STAR (Stop, Think, Assess, Review)

Quality indicators	
Dementia care	The home provides person centred care that reflects the changing needs of the individual. The home has relevant tools to support them in their work.

Supporting information:

Care Quality Commission (2011), Essential Standards of quality and safety: last reviewed online at http://www.cqc.org.uk/sites/default/files/media/documents/gac-dec

Department of Health (2015). Prime Minister's Challenge on Dementia 2020. DoH. London.

James, I.,J. (2011). The Newcastle Model (understanding behaviour in Dementia that challenges), Jessica Kingsley Publishers.

Kitwood, T. (1997). How personhood is understood. Dementia reconsidered: The person comes first. Buckingham: Open University Press, pp. 37-53.

National Dementia Strategy 2009, (revised 2013) Department of Health.

National Institute for Health and Care Excellence (2013). Dementia: independence and wellbeing (Quality Standard 30). NICE. Manchester.

National Institute for Clinical Excellence (2010).

Quality statement 7: Non-cognitive symptoms and behaviour that challenges. NICE. London.

National Institute for Health and Clinical Excellence and Social Care Institute for Excellence (2006).

Dementia: Supporting People with Dementia and their Carers in Health and Social Care. Clinical practice guideline 42. NICE, London.

NHS
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OPERATING STANDARD

Procedure: Parkinson's and the management of acute deterioration of symptoms	
Number: 7	
Author(S): Lynne Osborne	
Date: July 2019	**Review Date:** July 2020

Topic overview

Throughout the disease progression it is known that Parkinson's symptoms can significantly worsen, this is not always related to a change in medication. Most commonly Parkinson's disease symptoms deteriorate when infection is present for example urinary tract and chest infections, wounds and infected rashes. Symptoms may also deteriorate when constipation is unmanaged or if Parkinson's medication is not taken on time every time.

There are a higher number of people with Parkinson's disease admitted to hospital in Cornwall resulting from urinary tract / chest infections, falls and cognitive impairment (Parkinson's UK Data Dashboard 2018, Neurowatch Data Profile 2013). People with Parkinson's also have a longer than average hospital admission in Cornwall (Parkinson's UK Data Dashboard 2018,Neurowatch Data Profile 2013) and previous audit findings of patient experiences during hospital admission has been variable (Parkinson's UK National Audit 2017) in part due to medication not been given on time (RCHT Information and Performance 2019, NICE 2017).

In terms of reducing hospital admissions the acute deterioration pathway has been developed by the Parkinson's team. It is suggested this pathway will provide guidance regarding the management of people with Parkinson's within the care home environment if symptoms acutely deteriorate.

Commissioner requirements

The commissioner expects that all providers will ensure they deliver high quality care to people with Parkinson's, ensuring that where appropriate medication is self-administered and given on time or within 30 minutes of its prescribed time (NICE 2018). Parkinson's medications are listed as critical medication. The commissioner expects all providers to familiarise themselves with the acute deterioration pathway.

Providers will

- Ensure that all residents with Parkinson's receive their medication on time every time. Parkinson's symptoms can fluctuate over the course of the day.
- Ensure that residents have an adequate fluid intake to reduce the likelihood of

urinary tract infections.

- Ensure that residents with Parkinson's do not become constipated, as this will affect medication absorption. The medication of choice is often Macrogol (laxido).
- Ensure that the person with Parkinson's is able to swallow their medication /food / fluid without any difficulties. If problems taking the prescribed medicines are encountered, please seek advice from the Parkinson's specialist team. Oral medicines should not be routinely switched to unlicensed liquid preparations as the change could adversely affect the person's condition. If there is a swallow difficulty a speech and language therapy referral may be required.
- If a recent medication change has been made and the symptoms appears to be clinically worse contact the Parkinson's specialist team for advice.
- Rule out the following if a residents **Parkinson's symptoms*** acutely deteriorate:
  - An underlying UTI as per pathway.
  - An underlying chest infection.
  - Wounds /rashes for signs of infection.
  - Constipation
  - Is the resident taking their medication as prescribed within the defined time?
- Contact the Parkinson's team for advice if a residents Parkinson's symptoms acutely deteriorate and all the above measures have been followed via email on pdnurses.cornwall@nhs.net

***Parkinson's symptoms include: tremor, slowness, stiffness, gait change ie shuffling / freezing, impaired balance, falls, dyskinesia, anxiety, depression, hallucinations, and confusion.**

Quality indicators	
Parkinson's Disease	All residents with Parkinson's disease receive their medication within 30 minutes of its prescribed time. This is one of the Quality Standards within the 2017 updated Parkinson's Disease Nice Guidance https://www.nice.org.uk/guidance/qs164/chapter/Quality-statement-4-Levodopa-in-hospital-or-a-care-home

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Please complete all 4 steps

IS YOUR PARKINSONS PATIENT EXPERIENCING ACUTE DETERIORIATION IN THEIR MOTOR SYMPTOMS?
(tremor, bradykinesia, rigidity, speech)

Deterioration within the last month?

YES

1. Is Infection Present?

NB. PD patients do not always display signs of infection therefore please consider all potential worsening symptoms* and carry out the tests below:

1) Urinalysis (if answering yes to two or more of the worsening symptoms and positive urinalysis consider antibiotics, prior to MSU results being received)
2) Blood tests inc. FBC, U&E's, CRP, TFT's
3) Examine chest
4) Any wounds, infected rashes?

↓

YES

POSTIVE INFECTION SCREEN:
Once treated patient should return to their normal level of functioning.

*worsening symptoms include:
increased tremor, bradykinesia, rigidity, reduced speech or swallow, reduced mobility, falls, confusion, hallucinations.

2. Is The Patient Constipated?

Have bowels opened within the last 2 days (or consistent with patients normal bowel habit)?

↓

YES

CONSTIPATION PRESENT:
Treat accordingly (NB: laxative of choice in PD is Macrogol (Laxido) but choice of laxative depends on individual patient.

3. Has the patient been prescribed any new medications within the past month?

↓

YES

Is it one of the medications listed overleaf?

↓

YES
Please consider discontinuing medication(unless anti-psychotic or lithium) or use an alternative & symptoms should improve after 2 weeks. *Consider a referral to the Pharmacist for a medication use review.*

NO

4. Is the patient taking their medications as prescribed? (Correct doses and times)

NO

Consider simplifying the drug regime if possible in conjunction with PD nurse. Also refer to Community Pharamacist/GP dispensary for further assessment.

YES

REFER TO PARKINSONS DISEASE NURSING SERVICE
01209 318048

Medications associated with a worsening of Parkinsons Disease symptoms

Anti-emetics:
Metoclopramide (Maxolon)
Prochlorperazine (Stemetil)
Cyclizine (Valoid)

Anti-histamines:
Alimemazine Tartrate (Alimemazine)
Chlorphenamine (Piriton)
Clemastine (Tavegil)
Promethazine Hydrochloride (Phenergan)

It is mainly the older anti-histamines as stated above that can cause problems in Parkinsons symptom control. Deterioration in Parkinsons symptoms is less likely in the non-sedating anti-histamines (Acrivastine, Bilastine, Cetirizine, Loratadine, Desloratadine, Fexofenadine, Mizolastine and Rupatadine) as they only penetrate the blood brain barrier to a slight extent.

Local formulary choices include generic Loratadine and Cetirizine.

Others:
Lithium (Priadel, Camcolit, Liskonum)
Cinnarizine (Stugeron, Arlevert)

Anti-psychotics will cause deterioration in Parkinsons symptoms. Atypical anti-psychotics may be safer than typical anti-psychotics but may have been prescribed to control Parkinsons psychosis. Please **do not stop treatment** but seek further advice.

NB: Please refer to the British National Formulary appendix 1: interactions when prescribing new medications for patients taking anti-Parkinsonian medications

NHS
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Clinical Commissioning Group

OPERATING STANDARD

Standard: Use of Medical Devices	
Number: 8	
Author(S): Heather Newton	
Date: May 2019	**Review Date:** May 2020

Topic overview

A medical device is an instrument, apparatus, implant, in vitro reagent or similar that is used to diagnose, prevent or treat disease or other conditions. It does not achieve its purpose through chemical reaction within or on the body. Medical devices vary in complexity and application and range from a medical thermometer or disposable gloves to larger electro mechanical equipment such as patient hoists.

Care Homes are required to ensure that the procurement, maintenance, use and storage of medical devices comply with National standards (MHRA and CQC). Clinical staff within Care Homes must be competent in the safe use and storage of medical devices.

The risk of not managing medical devices correctly has been recognised by the Care Quality Commission Essential Standards of Quality and Safety Outcome 11 which refers to the safety, availability and suitability of equipment. People should be safe from harm from unsafe or unsuitable equipment.

Commissioner requirements

The commissioner expects that Care Homes will manage all of the elements relating to medical device management in the home in such a way as to ensure that people and staff remain safe from harm.

Providers will

- Have a robust process for the procurement of medical devices to ensure that it meets with all regulatory standards.
- Have a robust process for the installation and on-going maintenance of relevant medical devices demonstrating evidence of safety checks where appropriate.
- Ensure that all medical devices are stored safely and securely to prevent theft, damage or misuse.
- Ensure that medical devices are disposed of or recycled safely and securely. Modifications should only take place in line with manufacturer's instructions.
- Have clear procedures in place for the safe use of medical devices. This should include the availability of medical device product guidance.
- Ensure that where equipment is provided as part of regulated activity, risks are assessed, monitored and reviewed.

- Ensure that the type and range of equipment used in the Care Home promotes independence, comfort, privacy and dignity and that equipment is available to service users when required.
- Ensure that medical devices are only used for the purpose to which they have been deemed suitable by the manufacturer. Items deemed for single use and single patient use must be used according to manufacturer's guidance.
- Ensure that competency based training programmes are in place for the safe use of medical devices. Staff should only use medical devices once they know how to use and operate them correctly.
- Have arrangements in place for reporting of adverse events, incidents, errors and near miss reporting related to medical devices in a timely manner. Outcome reporting should promote opportunities for shared learning.
- Have in place contingency plans for the use of medical devices if there is a failure of essential services such as electricity and water.

Quality indicators	
Use of medical devices	The home has clear procedures in place for the safe use of medical devices.

Supporting information:

CQC (2011) Essential Standards of Quality and Safety Dec 2011 updated
http://www.cqc.org.uk/sites/default/files/media/documents/gac_-_dec_2011_update.pdf

MHRA (2015) Managing Medical Devices – Guidance for Health and Social services organisations.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/421028/Managing_medical_devices_-_Apr_2015.pdf

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OPERATING STANDARD

Procedure: Long Term Conditions and Frailty Case Management	
Number: 9	
Author(S): Marie Prior	
Date: May 2019	**Review Date:** May 2020

Topic overview

In England today 60 per cent of adults report a chronic health problem and 8.8 million have a long term condition that severely limits their day to day ability to cope. Multiple long term conditions make care particularly complex, and a small number of patients and diseases account for a disproportionate amount of health care use.

Residents of Care Homes have complex healthcare needs, reflecting multiple long-term conditions, significant disability and frailty (BGS, 2011). A study undertaken to compare the quality of chronic disease care for older people in Care Homes with that undertaken in the community (Shah et al 2011) identified that there is scope for improving the management of chronic diseases in Care Homes, and that attainment of quality indicators was significantly lower for residents of Care Homes than for those in the community.

Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, chronic obstructive pulmonary disease, angina, epilepsy and hypertension. Actively managing patients with ACS conditions – through vaccination; pro-active disease-management or case-management; prevents acute exacerbations and reduces the need for emergency hospital admission (The Kings Fund, 2011).

Commissioner requirements

The commissioner expects that providers will comply with the requirements of case management, including pro-active identification of early deterioration, action to effectively and promptly manage any acute events, and to be able to provide evidence to that effect. In doing so residents and staff will be protected from deterioration and harm.

Providers will:

- Ensure that their workforce have acquired or are supported to acquire the relevant knowledge, skills and competencies to enable them to effectively manage residents with long term conditions and frailty and to ensure an informed and confident care service.
- Ensure that condition specific care plans are implemented to support evidence based care and proactive case management. Care plans will reflect the management of individual long term conditions and identify the actions that need to be undertaken by the Registered Nurse and/or care worker.
- Clinical staff identify frailty and implement strategies to ensure that effective

and consistent management of symptoms or disability and act promptly on any deterioration or changes.

- Review whether interventions to manage symptoms are effective for the individual and discuss with GP or specialist service as necessary.
- Monitor the condition of individuals and take appropriate action to remedy any problems or adverse effects.
- Evaluate and analyse all acute hospital admissions from the home and identify actions to reduce re-occurrence.

Quality indicators	
Long term conditions case management	Clinical staff in the home are trained and have evidence to show how to identify frailty, new symptoms, changes in existing symptoms, holistic assessment, recognition of aggravating factors and deterioration and to be able to instigate prompt action to support the treatment and management of long term conditions, frailty and complex care

NHS
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OPERATING STANDARD

Standard: Care Planning and Record Keeping	
Number: 10	
Author(S): Jo Dolton	
Date: May 2019	**Review Date:** May 2021

Topic overview
Good Care Planning and record keeping is an integral part of nursing practice, and is essential to the provision of safe and effective care.

Commissioner requirements
It is expected that all providers delivering residential or nursing care, will ensure that they deliver on their 'core responsibility to provide safe, effective and high quality care' (statement of government policy on adult safeguarding May 2013) to all people residing and receiving care in their establishment. Individuality and person centred care planning and effective record keeping is essential to this requirement.

Providers will
• Ensure that all Nursing Staff are aware and understand the NMC professional code of practice, and are aware of the NMC guidance on record keeping. • Provide training to ensure that all nursing staff are competent in the understanding of how to formulate, action and evaluate a care plan and produce effective care records. • Provide training to ensure that all care staff understand the components and the reasoning for care plans to deliver effective safe care and the need to produce effective care records. • Provide clear guidance/standards to all nursing and care staff in the delivery of effective individualised (personalised) care planning and promoting empowerment for the person whose care is being devised. • Ensure that care plans address all care domains appropriately. • Ensure that within supervision processes, care planning and effective record keeping is discussed, and competence is assessed.

Quality indicators	
Care planning and record keeping	There is evidence of staff competence in planning, implementing and evaluating care. Staff meet NMC and CQC guidance on record keeping.

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OPERATING STANDARD

Procedure: Dignity and Respect	
Number: 11	
Author: Heather Anderson	
Date: May 2019	**Review Date:** May 2020

Topic overview

The principles on which the home's philosophy of care is based must be the ones which ensure that residents are treated with respect, that their dignity is preserved at all times, and that their right to privacy is always observed.

Commissioner requirements

In meeting a key foundation of dignified care the commissioner requires all care staff to adopt the concept of *'always events'* for delivering dignity in care, that is:
Always:

- Treat those in your care as they wish to be treated, with respect, dignity and courtesy.
- Remember the resident's nutrition and hydration needs.
- Encourage formal and informal feedback from older people and their relatives, carers and advocates, to improve practice.
- Challenge poor practice at the time and learn as a team from the error.
- Report poor practice where appropriate, the people in your care have rights and you have professional responsibilities.

Providers will

- Give guidance to all their staff on treating residents with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
- Train and assess staff competency in relevant communication skills including their ability to communicate warmth and kindness.
- Ensure residents are introduced to all healthcare professionals involved in their care and that staff use the term of address preferred by the resident.
- Ensure that every resident has a care plan that identifies their own wishes, preferences and priorities and addresses the support they need to retain and develop their sense of dignity and personal identity.
- Ensure care plans evidence that respect is shown for residents' cultural background, gender, age, sexuality, religion or belief and disability if applicable.
- Actively involve residents in shared decision making and support them to make fully informed choices about investigations, treatment and care.
- Respect and review residents' preferences for sharing information with partners, family members and/or carers:
  - Ensure care plans are kept up to date as the residents circumstances change.

- Ensure that when delivering personal care such as nursing, bathing, washing and assisting the resident using the toilet that the resident' privacy and dignity are respected at all times.
- Do their best to develop an 'enriched environment for residents, family and friends. This will include access to meaningful activity.
- Ensure residents have easy access to a telephone for use in private.
- Ensure residents wear their own clothes at all times.

Quality indicators	
Dignity and Respect	There is evidence in the home that residents' wishes, preferences, priorities and beliefs are taken into account.

Supporting Information:

'Always events' - https://www.england.nhs.uk/always-events/

'Always events' Toolkit - https://www.england.nhs.uk/wp-content/uploads/2016/12/always-events-toolkit-v6.pdf

Patient experience in adult NHS services: Improving the experiences of care for people using adult NHS Services. NICE Guideline qs15.
https://www.nice.org.uk/guidance/qs15

Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE Guideline cg138.
https://www.nice.org.uk/guidance/cg138

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OPERATING STANDARD

Procedure: Clinical Supervision	
Number: 12	
Author(S): Jo Dolton	
Date: May 2019	**Review Date:** May 2020

Topic overview

Supervision is a "formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility f their own practice and enhance consumer protection" (DOH1993).
Supervision assists in developing a positive culture in a provider and focuses on continuous improvement and consistent practice helping to improve outcomes for vulnerable people.

Commissioner requirements

The commissioner expects that all providers delivering residential or nursing care, will ensure that they deliver on their 'core responsibility to provide safe, effective and high quality care' (statement of government policy on adult safeguarding May 2013) to all people residing and receiving care in their establishment. Clinical supervision is integral in this process and it is expected that formal supervision is embedded into every employees working life (supported by NMC Standards of conduct, performance and ethics for nurses and midwives).

Providers will

- Understand and promote a culture that clinical supervision will assist in supporting person centred and safeguarding standards of care whilst supporting growth and professional development for the clinician /carer.

- Ensure an appropriate framework for clinical supervision is in place for all staff taking into account and delivering on diversity within the workforce. To include:
  - Focus on patient care.
  - Reflection on clinical practice and safeguarding principles:
    Empowerment – Presumption of person led decisions and informed consent.
    Prevention – It is better to take action before harm occurs.
    Proportionality – Support and representation for those in greatest need.
    Partnership – detecting and reporting neglect and abuse.
  - Process of learning by supervisee *(*e.g. how learning is embedded into the workplace to improve outcomes for people using the service*).*

- Professional support for the supervisee.
- Championing the importance of clinical supervision at all levels.

- Ensure provision of training and development for clinical staff to enable them to act in the capacity of a Clinical Supervisor:
  - The identification and training of individuals who could facilitate group/ peer supervision.
  - Ensuring staff have the opportunity to share learning outside their teams or individual sessions if they feel others may benefit from their experiences.
  - Linking systems of clinical supervision to clinical governance, Appraisal and Revalidation.
  - Ensuring clinical supervision is supported and that clinical staff have sufficient protected time to access appropriate supervision.
  - Ensuring appropriate records of supervision are kept securely .
  - Ensuring a reference to supervision is included in all recruitment processes.

Quality indicators	
Clinical Supervision	An appropriate framework for clinical supervision is used in the home.

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OPERATING STANDARD

Standard: Safeguarding Adults	
Number: 13	
Author(S): Jo Dolton	
Date: May 2019	**Review Date:** May 2021

Topic overview

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure the adults wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action.

Organisations must always promote the adults wellbeing in their safeguarding arrangements. Safeguarding is not a substitute for provider's responsibilities to provide safe high quality care and support (Care Act 2014).

Commissioner requirements

The commissioner expects that providers will comply with the requirement of safeguarding adults, including the pro-active identification of abuse and neglect and the appropriate implementation of the local safeguarding adults' procedures, from raising alerts to attendance at meetings and full co-operation with the process. Working with the Local Authority Quality Assurance team, NHS Kernow Safeguarding Adults Leads and the Continuing Health care team where necessary.

Providers will

- Ensure that their workforce have acquired or are supported to acquire the relevant level of safeguarding adults training. To include mental capacity act, deprivation of liberty, safeguarding adults and human rights.
- Ensure that they have in place comprehensive safeguarding adults policies and procedures that are integrated to the local safeguarding adults' boards' policies and procedures. To include whistle blowing policy.
- Ensure that all staff act at all times in a manner that promotes the dignity and respect of all residents.
- Ensure that all staff know how to recognise abuse and neglect and are aware of how to raise a safeguarding adult's alert.
- Ensure that robust, regular clinical supervision is in place for all staff.
- Ensure that records are kept of all safeguarding alerts raised regarding the

home and their outcomes.

Quality indicators	
Safeguarding adults	All staff know how to recognise and prevent abuse and neglect and are aware of how to raise a safeguarding adults alert and how to ensure an individual is kept safe.

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OPERATING STANDARD

Standard: Incident reporting	
Number: 14	
Author(S): Gillian Dinnis	
Date: June 2019	**Review Date:** June 2020

Topic overview

It is important that safety incidents that could have or did harm a patient or client receiving NHS funded care are reported so they can be learnt from and any necessary action can be taken to prevent similar incidents from occurring in the future. Learning from incidents can only be achieved if they are routinely reported and shared, so all providers of NHS funded care need to have local incident reporting systems in place and should encourage their staff to use them.

Commissioner requirements

When an incident occurs that could have or did harm a patient or client it must be recorded on a local reporting system. The record should identify, as a minimum, what happened, to whom (preserving confidentiality), when and how the incident occurred with actions taken to ensure or restore the safety of all individuals affected and subsequent actions taken to prevent similar incidents occurring in future.

Patient safety can be categorised using these topic headings:

- Abuse/aggression
- Consent, communication, confidentiality
- Documentation (including checklists/patient records)
- Environment (including cleaning)
- Human factors and patient safety culture (including, teamwork, staffing)
- Medical devices/equipment
- Medication safety
- Patient accident (including slips, trips and falls)
- Patient admission, transfer, discharge (including patient ID)
- Patient assessment and diagnosis (including tests)
- Patient treatment/procedure (including nutrition)
- Risk assessment and patient safety

Providers will
• Ensure there is a system in place to record safety incidents • Ensure staff are aware of the need to report safety incidents and the systems in place • Ensure all safety incidents are recorded and that any incidents requiring external reporting (such as RIDDOR, CQC, Serious Incidents Requiring Investigation) are identified and reported appropriately • Take action immediately following any incident to ensure the safety of all those affected is restored and maintained, and to ensure the safety of others who are not immediately affected is not compromised • Follow up all incidents with appropriate measures to prevent similar incidents happening again • Inform patients about safety incidents that affect them

Quality indicators	
Incident reporting	There is evidence that all incidents are reported and recorded and actions taken as applicable.

Supporting information:

Safety first: a report for patients, clinicians and healthcare managers
Department of Health, published December 2006

NHS England website: Reporting patient safety incidents
http://www.england.nhs.uk/ourwork/patientsafety/report-patient-safety/

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Procedure: Serious Incidents	
Number: 15	
Author(s): Lisa Nightingale	
Date: May 2019	**Review Date:** May 2020

Topic overview

A serious incident is an incident that results in one or more of the following:

- unexpected or avoidable death or severe harm of one or more patients, staff or members of the public
- a 'never event' - as defined in the Never Events 'Policy framework for use in the NHS'
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population
- allegations, or incidents, of physical abuse and sexual assault or abuse
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation

If a serious incident occurs during NHS funded care (including in the community), national guidelines require a thorough investigation to be undertaken. Serious incidents are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again.

Commissioner requirements

When an incident occurs that fits, or appears to fit, the criteria for a serious incident it must be reported to the Clinical Governance Lead NHS Kernow, the commissioner and all other relevant bodies. The commissioner expects providers to meet the requirements of KCCG Policy and Procedure for Reporting and Learning from Serious Incidents Requiring investigation.

Providers will

- Report serious incidents within 2 working days of discovery.
- Collaborate with investigations and any remedial work required following investigations.
- Keep records of serious incidents including data on the numbers and types of incidents, excluding material that would compromise patient confidentiality.
- Comply with national requirements and guidance in relation to being open with patients or their representatives when things have gone wrong.

- Provide relevant guidance and training for staff to help them identify and report incidents.
- Ensure that action plans are implemented.

Quality indicators	
Serious incidents	Staff understand what is meant by the term serious incident, and how and to whom these should be reported.

Supporting Information:

NHS England Serious Incident framework March 2015
http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
NHS Kernow Policy and Procedure for Reporting and Learning from Serious Incidents Requiring Investigation
http://intra.cornwall.nhs.uk/GET/d10284973

Kernow Clinical Commissioning Group

OPERATING STANDARD

Standard: Human Resources	
Number: 16	
Author(S): Isobel Ryder	
Date: April 2019	**Review Date:** April 2021

Topic overview
Reasons for developing these standards are to ensure: • Recruitment and selection is fair and effective. • Professional Standards are maintained. • Managers are competent, and employees are appropriately trained and developed. • Equality is central to policies, procedures, and ways of working. • Policies are clear and communicated. • The importance of health at work is recognised. • Legal obligations are understood and adhered to.

Commissioner requirements
It is expected that providers will support their staff to be competent and confident in delivering and evidencing the key requirements set out in this standard; and to comply with the legal requirements of employing people.

Providers will
• Ensure recruitment and selection is fair and non-discriminatory to include clear job descriptions and person specifications, at least two people on interview panels to prevent bias, and records of the interviews are kept. • Check references (ideally 2 professional references from the most recent employer(s) covering a period of at least 3 years), qualifications, and entitlement to work in the UK; and carry out Disclosure and Barring Service (DBS) checks for relevant roles, before commencing employment. • Provide a comprehensive induction for staff to include (as a minimum) manual handling, personal safety, conflict resolution (and/or breakaway) confidentiality and safeguarding training. • Issue all employees with a contract of employment in accordance with the legislative requirements. • Meet the legal requirements of minimum wage and equal pay. • Allow employees to take proper breaks in line with the Working Time Regulations, and use their full annual leave entitlement. • To facilitate the requirements of and comply with the Health & Safety At Work Act 1999 (as amended). This would include the implementation of protocols for risk assessments and incident reporting as well as a duty of care for health and wellbeing.

OPERATING STANDARD

- Hold formal appraisals, and use them to provide the basis for making development and improvement plans.
- Have supervisory or peer support arrangements in place.
- Ensure disciplinary and grievance procedures follow ACAS code of practice (tribunals take this into account), make employees aware of your procedures and expectations, and monitor and review these procedures.
- Have clear policies to prevent unacceptable behavior at work: Equality & Diversity policy/Bullying & Harassment policy. Make employees aware of the requirements and standards set out in these policies.
- Ensure nurses and other qualified employees maintain their professional competence and minimum levels of qualifications.
- Ensure all employees are competent and have the required qualifications, knowledge, skills and experience to carry out their role. Provide the required training and development as needed.
- Ensure employees are registered with the relevant professional regulator or body when necessary and are allowed to work by that body.
- Ensure Professional Registration is current, kept up to date and monitored to prevent lapses in line with Nurse Revalidation standards.
- Where there are concerns regarding staff performance (ie capability, safeguarding), and individuals meet the requirement for referral, where applicable, ensure the appropriate professional bodies are notified through the correct process and procedure. Irrespective of whether an individual is not affiliated to a professional body, safeguarding concerns should be raised with the local safeguarding teams and if necessary the police. Policies should be in place to reflect this.
- Ensure staffing levels are appropriate and there are systems in place to monitor and cover when staffing levels are affected by absence and emergency.
- Assess the skill mix of the organisation and take measures to address any imbalances.
- Process all personal and employee data in line with the required legislation ie Data Protection Act and General Data Protection Act

Quality indicators	
Human Resources	The workforce has the required skills, competencies and support to be effective, and operates within the appropriate legal frameworks for employing people

Supporting Information:
Advisory, Conciliation and Arbitration Service www.acas.org.uk
GOV.UK - www.gov.uk (Employing People section)

Kernow Clinical Commissioning Group

OPERATING STANDARD

Procedure: Managing Complaints	
Number: 17	
Author(S): Jayna Chapman and Jodeigh Phelps	
Date: July 2018	**Review Date:** July 2020

Topic overview

The law requires a complaints procedure to be in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf. This should be in line with the requirements of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
http://www.legislation.gov.uk/uksi/2009/309/pdfs/uksi_20090309_en.pdf

Commissioner requirements

The commissioner expects all patients to have knowledge and information about the complaints procedure and to be able to use it without fear that their care may be compromised as a result of making a complaint.

The commissioner expects the provider to monitor complaints and positive feedback from service users, and to provide evidence that learning and improvements result from this.

Providers will

- Provide information about the complaints procedure to all residents, in formats that are appropriate to their individual needs.
- Provide information and contact details of appropriate complaints advocacy.
- Provide information about the second stage of the complaints procedure, which is to contact the appropriate Ombudsman.
- Have appropriate procedures in place for handling complaints, in line with the complaints regulations, including responding in ways which are appropriate to the complainant's individual needs.
- Ensure that any complaint is fully investigated, and as far as practicable, resolved to the complainant's satisfaction.
- Be able to demonstrate a learning culture by showing examples of changes which have been made as a result of complaints.
- Be able to produce, upon request, evidence of complaints made and responses and action taken.
- Act in line with the Principles of Good Complaint Handling as issued by the Parliamentary and Health Service Ombudsman http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full.

Quality indicators	
Managing complaints	The home has appropriate procedures in place for handling complaints. A record of complaints made and the learning will be maintained.

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Standard: Whistleblowing	
Number: 18	
Author(S): Isobel Ryder	
Date: May 2019	**Review Date:** May 2020

Topic overview
The process by which a member of staff can raise a concern about a possible risk, wrong-doing or malpractice that has a public interest aspect to it. The provider is expected to engender a culture which encourages openness and within which people feel able to speak-up about their concerns.

Commissioner requirements
Whistleblowing is a way for concerns to be raised about possible danger, professional misconduct or financial malpractice that has a public interest to it, usually because it threatens or poses a risk to others, e.g. patients, public, colleagues or the organisation. This applies to all members of staff, volunteers and agency workers.

Providers will

- Have a whistle blowing policy in place, in date and accessible to staff.
- Recognise that an individual does not need to provide firm evidence to raise a concern. However he or she will need to provide as much information as possible about the circumstances that gave rise to that concern.
- Recognise that individuals may prefer to speak to someone in confidence about their concern.
- Ensure that they have mechanisms in place to protect the identity of the whistle blower if consent to disclose is not given, unless required to do so by law.
- Understand there may be circumstances where it is impossible to resolve a concern without revealing an individual's identity.
- Ensure that no one is discriminated against or suffers any detriment as a result of raising a concern.

Individual should:

- Wherever possible, raise any concerns with your line manager or lead clinician at the first instance, either verbally or in writing; providing as much information as possible.
- Arrange other reporting routes if it is not possible to raise the matter with the line manager or lead clinician.

If staff are still unsure about Whistleblowing or would like further confidential advice, then they should contact their union or the Whistleblowing Helpline **(**for the NHS and social care) your professional body or trade union representative.

The Whistleblowing Helpline is a free-phone service for employees, and organisations working within the NHS and social care sector, and is for**:**

NHS staff (including trainees and agency staff)
Staff in the social care sector (including trainees and agency staff)
NHS and social care employing organisations
Contractors for the NHS and social care sector
Trade unions
Professional bodies

Tel: 08000 724 725 email:enquiries@wbhelpline.org.uk
Speak Up
We recognise there may be circumstances when you may need to report to an outside body. Other bodies you can report to include:

NHS Improvement
0300 123 2257
enquiries@improvement.nhs.uk
Wellington House
133-155 Waterloo Road
London
SE1 8UG
For concerns about:
o How NHS trusts and foundation trusts are being run
o Other providers with an NHS provider licence
o NHS procurement, choice and competition
o The national tariff

NHS England
0300 311 22 33
england.contactus@nhs.net
NHS England, PO Box 16738,
Redditch, B97 9PT
for concerns about:
o Primary medical services (general practice)
o Primary dental services
o Primary ophthalmic services
o Local pharmaceutical services

The National Audit Office
Whistleblowing Hotline - 020 7798 7999
enquiries@nao.gsi.gov.uk

Care Quality Commission (CQC)
03000 616161
enquiries@cqc.org.uk
CQC National Correspondence
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
for quality and safety concerns

The **Local Counter Fraud Specialist**
07774 779587
Byron.Kevern@tiaa.co.uk

or the **NHS Counter Fraud Authority**
0200 028 4060 (Crimestoppers)
generalenquiries@nhscfa.gsi.gov.uk
Online Fraud Reporting Tool
Skipton House
80 London Road
London
SE1 6LH
for concerns about fraud and corruption.

CQC Whistleblowing Quick Guide for Staff
CQC Whistleblowing Guidance for Providers

Quality indicators	
Whistleblowing	Staff aware of how to raise a concern and are confident that they will not suffer any detriment as a result of this.

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Standard: Medicines Management	
Number: 19	
Author(S): Amanda Pell	
Date: July 2018	**Review Date:** March 2020

Topic overview

Across all sectors of care, it is estimated that at least 6% of emergency admissions are a direct result of problems with medicines. Data within Cornwall shows that many of our Care Homes residents take multiple medications and as such are at greater risk of drug interactions and medicine related admissions to acute care.
Regulation 12: Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) state that a registered person must ensure "the proper and safe management of medicines" in order to comply with the regulations.

Commissioner requirements

The commissioner expects that homes will manage the safe ordering, receipt, storage, administration, and disposal of medication in the home in such a way as to ensure that people get the medicines they need when they need them, managing waste and reducing the risk of medication errors. Ordering of medication must not be delegated to a third party (e.g. supplying pharmacy).

Providers will

- Have a robust medicines policy that covers all aspects of ordering, receipt, storage, administration and disposal of medicines. All staff will need to evidence that they have read and understood this document and the expectations placed upon them and evidence that they abide by it.
- Manage day to day administration of medicines as per the organisation's medication policy.

Specifically, they will ensure:-

- That a medication policy is in place which is monitored and reviewed regularly.
- The medication policy should include all aspects of medicines management as covered in the NHS Kernow document 'Medicines management framework for care homes'.
- All staff involved in medicines management have completed an accredited training course and refresher courses. Medication training should include basic information on common types of medicines and their use, the legislative framework for the use of medicines in care homes, how to safely administer, receive, store and dispose of medicines, how to support the resident in taking their medication and promote their rights and how to effectively and safely record and report on the use of medicines.
- Orders for medication are placed in a timely manner to reduce the risk of a patient being without medication, for example, not ordering last minute or at weekends. A procedure should be in place for obtaining emergency supplies of medicines for example on bank holidays.
- Staff ordering medication have protected time for the task
- At least two members of the care home staff have the training and skills to order medicines, although ordering can be done by one member of staff. Stock balances are checked before orders are made and particularly for medicines that are prescribed as "when required" and inhalers

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

- All medication is stored safely and securely and medication trolleys must be secured to a wall when not in use. NB The temperature of the storage area **must not** exceed 25^{o}C.
- Daily records should be kept of the ambient storage temperature and there must be a process to follow if the temperature is outside the range.
- Keys to medication storage areas are always in the possession of a trained senior member of staff.
- All medicines requiring cold storage must be stored securely in a fridge (preferably lockable) which is used solely for that purpose. Temperature must be in the range 2-8°C.
- A maximum/minimum thermometer must be used to check fridge temperature daily and then reset. (Maximum and minimum temperatures must be recorded.
- A procedure must be in place detailing action to take if the temperature of the fridge is outside
- There should be a clear audit trail for the transfer of keys for the medication storage areas.
- The medication policy includes a process for the administration of “when required” or “as needed” (prn) medicines ensuring that residents are monitored to assess the need for “when required” or “as needed” (prn) medication e.g. reviewing the need for analgesia or laxative before administration.
- Medication is only administered to the person for whom they have been prescribed, labelled and supplied (including dressings and nutritional supplements, but excluding homely remedies.)
- There is a policy in place for the ordering, receipt, administration, storage and destruction of **Controlled Drugs** (CDs) and that this policy includes the reporting of incidents that involve CDs (including reporting to the CD Accountable Officer for NHS England at www.cdreporting.nhs.uk .
- All CDs are stored in a metal cupboard which complies with the misuse of Drugs (Safe Custody) Regulations 1973.
- CD Registers are kept from 2 years after the date of the last entry made.
- There is a policy in place for high **risk drugs** e.g.warfarin, which includes the requirement for changes in dose to be confirmed in writing.
- The medication policy contains a process for the management of patient safety /CAS alerts and ensures that all alerts received by the care home are cascaded to all relevant staff and are revisited to ensure continuing compliance.
- A policy exists for those who wish to retain responsibility for the self-management of some or all of their medication and a record are maintained of current medication for these residents.
- Medicines for disposal segregated from other stock by storing securely in a tamper-proof container within the medication cupboard until they are collected or taken to the pharmacy and clearly identified as for disposal and a record of medication returned to the pharmacy or disposed of via carrier is made.
- Care homes should keep a limited supply of **homely remedies** i.e. non-prescription or over-the-counter medicines for treating minor ailments such as constipation or headache and must have a homely remedy policy which names those members of staff who have been trained to administer these medicines.

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Quality indicators	
Ordering and receipt of medication	Residents are not without their medication because there is no stock in the home.
Medication Policy	Active and in date, covering all aspects of medicines management, regularly reviewed and signed as read by all staff within the last 12 months
Homely remedy Policy	Active and in date, covering minor ailments and self-limiting conditions for which treatment with OTC medicine would be permitted as per NHS England guidance

Supporting information:

- NICE SC1 Managing medicines in Cares Homes https://www.nice.org.uk/guidance/sc1
- NICE CG76. Medicines Adherence – Involving patients in decisions about prescribed medicines and supporting adherence. http://www.nice.org.uk/CG76
- Care Quality Commission (2015) Guidance for providers on meeting the regulations: Health and Social Care Act 2008 (regulated activities) Regulations 2014 (part 3) (as amended), Care Quality Commission (registration) Regulations 2009 (part 4) (as amended) available at http://www.cqc.org.uk/sites/default/files/20150210_guidance_for_providers_on_meeting_the_regulations_final_01.pdf (accessed 26th May 2017)
- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline [NG5] Published date: March 2015. Available at https://www.nice.org.uk/guidance/ng5 (Accessed 26th May 2017)
- Conditions for which over the counter items should not routinely be prescribed in primary care. NHS England 2018 Available at https://www.england.nhs.uk/publication/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed-in-primary-care-guidance-for-ccgs/ (Accessed June 2018

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Standard: Clinical Skills and Procedures	
Number: 20	
Author(s): Marie Prior	
Date: May 2019	**Review Date:** May 2020

Topic overview

Clinical staff within care homes needs to be both competent and confident in undertaking a range of clinical skills and associated procedures for residents in their care.

Commissioner requirements

It is expected that care home providers will support their clinical staff in attaining, maintaining and evidencing competence in undertaking the skills identified in this operating standard.

Providers will

Providers will ensure that the clinical management skills listed below are provided and available 24 hours a day as part of Registered Nursing care delivery.
It should be noted that separate operating standards exist for a number of the clinical management skills listed:

Hydration management	Nutrition management
Personalised care planning	Falls prevention
Palliative Care Planning	End of Life Care
Nursing management of LTC's	Management of complex wounds
Dementia management	Medicines management
Nebuliser & inhaler management	Anticipatory care planning
Symptom management & review	Continence management
Management of acute deterioration	Responding to changes in condition
Pain management	Diabetes Management
Bowel management	Management of urinary tract infections
Tissue Viability	Management of pressure ulcers
Non-complex leg ulcer management	Prevention of pressure ulcers

Providers will also ensure that staff employed by the home are competent in undertaking the clinical procedures listed below and that these skills are available 24 hours a day as part of Registered Nursing care delivery:

Venepuncture	Syringe driver management	Sub cut & IM injections
Manual handling	Enteral feeding	Suction
Peg feeding	Administration of eye drops	Administration of ear drops

Sub cut fluid therapy	Vaginal pessaries	Blood glucose monitoring
Insulin administration	Supra pubic re catheterisation	Catheterisation
Urinalysis	Blood pressure measurement	Pulse measurement
Wound care	Respiratory rate measurement	Pulse oximetry
Removal of sutures	Temperature measurement	Compression bandaging
Oxygen administration	Neurological observations	

Quality indicators	
Clinical skills and procedures	Clinical staff are trained and individually they have evidence that are maintaining their competence in undertaking the clinical skills identified in this standard.

NHS
Kernow
Clinical Commissioning Group

OPERATING STANDARD

Standard: End of Life Care	
Number: 21	
Author(S): Jo Smith, End of Life Facilitator, CFT	
Date: May 2019	**Review Date:** May 2020

Topic overview

This Operating Standard is written based on the principles of the Gold Standards Framework in Care Homes (GSFCH) training programme which was initiated with the nursing homes in Cornwall 2011/12.

In Cornwall 23.4% of deaths occurred in care homes (based on 2016 National End of Life Intelligence Network statistics).

In 2008 the first national strategy for end of life care in England galvanised the health and social care system with three key insights: that people didn't die in their place of choice; that we needed to prepare for larger numbers of dying people and that not everybody received high-quality care.
It is important to build on the strategy, but to reframe it in today's context with its emphasis on local leadership, service delivery and accountability. So, in this standard we use:

- Ambitions for palliative and end of life care
- Gold Standards Framework in Care Homes
- NICE guidance & quality standards: care of dying adults in the last days of life
- Priorities for care of the dying person

Care Home support must be focused around the individual and those important to them, locally led and delivered, and supported across all communities.

Commissioner requirements

The commissioner expects that providers will provide end of life care within the Ambitions / Gold Standards Framework (GSF). By doing so…..

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is co-ordinated
5. All staff are prepared to care
6. Each community is prepared to help

Providers will
Ensure the team has a system in place to identify those residents who are considered to be in the last year of life, best practice suggests utilising the GSF prognostic indicator guidance tool, incorporating GSF needs based coding system. Ensure residents clinical needs are assessed, in a holistic and dignified manner, demonstrating the use of appropriate assessment tools. Residents receive appropriate symptom and pain relief when required and without delay. Offer advance care plan discussions to all residents, determining resident's preferences and wishes and aligning care accordingly. Where the resident lacks capacity, facilitate best interest meetings, ensuring care is delivered in line with Mental Capacity Act (2005). Engage in effective cross boundary communication to the wider healthcare team, ensuring information about individuals who are approaching the end of life is available, in the right format, at the right time, to the right people. Ensure individual end of life care plans are implemented when residents' approach the last days of life, aligning the care given with the 5 priorities for care of the dying person. Ensure there is good care and support for the bereaved and staff, including staff supervision and written information and signposting for bereavement care. Incorporate reflection as standard practice, ensuring team reflection occurs following the death of a resident and following any acute hospital admissions. Discussion as a team to reflect on the care given, highlighting any key areas for improvement. Ensure staff educational needs are being met. All staff are skilled in needs assessment, care planning and advance care planning, ensuring staff are confident to facilitate effective conversations regarding end of life care.

Quality indicators	
Clients approach death / die in a supported, well managed way	Residents achieve their preferred place of care / death. They are cared for by staff who are confident and competent in end of life care.
Quality assurance	Staff have mechanisms to evaluate complaints and compliments relating to end of life care. After death analysis / reflective practice and education opportunities in place for staff.

Supporting Information:

Ambitions for palliative and end of life care. National Palliative and End of Life Partnership: A national framework for local action 2015 - 2020
http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf

End of Life Care for All (e-ELCA) free access to over 150 interactive sessions, including advance care planning, assessment, communication skills, symptom management, comfort and well-being, social care, bereavement and spirituality.
https://www.e-lfh.org.uk/programmes/end-of-life-care/

The Gold Standards Framework Centre and access to Proactive Identification Guidance: 6th Edition 2016 at http://www.goldstandardsframework.org.uk/

Care After Death: Guidance for staff responsible for care after death. Hospice UK 2015
https://www.hospiceuk.org/media-centre/press-releases/details/2015/04/22/updated-guidance-for-professionals-who-provide-care-after-death

One chance to get it right: Improving people's experience of care in the last few days and hours of life. Leadership Alliance for the Care of Dying People (2014)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

Department of Health (2008). End of Life Care Strategy: Promoting high quality care for all adults at the end of life. London: HMSO
https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

NICE guideline NG31 Care of dying adults in the last days of life (2015)
https://www.nice.org.uk/guidance/ng31/resources/care-of-dying-adults-in-the-last-days-of-life-1837387324357

NICE quality standard QS13 on end of life care for adults (2011) last updated March 2017
https://www.nice.org.uk/guidance/qs13/resources/end-of-life-care-for-adults-2098483631557

NICE quality standard QS144 Care of dying adults in the last days of life March 2017
https://www.nice.org.uk/guidance/qs144/resources/care-of-dying-adults-in-the-last-days-of-life-pdf-75545479508677

Advance Care Planning: planning for your future care: a guide (revised 2014)
http://www.nhs.uk/Planners/end-of-life-care/Documents/planning_for_your_future_updated_sept_2014%20(1).pdf

Treatment and Care towards the end of life (GMC 2010)
http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

NHS
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OPERATING STANDARD

Procedure: Diabetes	
Number: 22	
Author(S): Georgina Praed; Anne Jones	
Date: August 2019	**Review Date:** August 2020

Topic overview

Diabetes is a lifelong condition that causes a person's blood sugar (glucose) level to become too high.

There are two main types of diabetes:

Type 1 diabetes – where the body's immune system attacks and destroys the cells that produce insulin.
Type 2 diabetes – where the body doesn't produce enough insulin or the body's cells don't react to insulin.

Type 2 diabetes is far more common than type 1. In the UK, around 90% of all adults with diabetes have type 2.

People with diabetes need to eat healthily, take regular exercise and carry out regular blood tests to ensure their blood glucose levels stay balanced.

People diagnosed with type 1 diabetes also require regular insulin injections for the rest of their life.

Type 2 diabetes is a progressive condition and medication may eventually be required, usually in the form of tablets and sometimes insulin or other injected medications.

Diabetes can lead to various complications, including heart disease and stroke, loss of feeling and pain (nerve damage), foot problems (infections and ulcers), eye problems and problems with the kidneys.

Controlling the blood sugar level and having regular diabetes check-ups is the best way to lower a person’s risk of complications.

Commissioner requirements

The commissioner expects that all providers will ensure that they deliver high-quality individualised care to all patients/residents with diabetes in accordance with national standards and local guidelines; delivering best practice at all times.

Providers will

Ensure that:

- all staff are trained to have a level of knowledge about diabetes relevant to their role (including diet, exercise, medicines, 'sick-day rules', possible complications and emergency treatment of hypoglycemia
- Details of diabetes-specific care requirements are detailed for each resident with diabetes
- Medicines for diabetes, including fridge lines, are stored in accordance with the manufacturer's recommendations
- a suitable, healthy diet is provided for all people with diabetes
- any necessary monitoring equipment, including single-use lancets, is available
- a sharps bin is available and that all sharps are disposed of safely
- all patients/clients with diabetes are offered all appropriate checks relevant to their diabetes in a timely fashion
- the advice of a Health Care Professional (HCP) is sought if there are any concerns about a patient with diabetes if any new symptoms become apparent.

Health Checks for People with Diabetes, for information:

Annual (all people with diabetes)

- Influenza Vaccination offered
- Blood pressure*
- HbA1c*
- Foot examination
- Eye examination
- Kidney checks*
- Cholesterol
- Help with stopping smoking (if smoker)
- Aware of 'sick-day' rules, as appropriate
- Medication review
- Discussion/review with a Health Care Professional (HCP)

*Minimum annual – individual care plan should detail frequency

People injecting insulin (in addition)

- 'Home' blood glucose testing (as advised by HCP)
- The person is/remains confident and competent to self-administer (or suitable alternative arrangements are in place)
- Insulin device (pen etc.) remains appropriate for a person
- Insulin Passport is available and up to date
- Injection sites are reviewed for fatty lumps (lipohypertrophy) (These are

common when injecting insulin, but the advice of HCP must be sought if found)

Quality indicators

Quality requirement	Method of measurement
Staff receive relevant training and updates about diabetes	*Training records*
Details of diabetes-related care are documented in the individual record for every person with diabetes and these are reviewed regularly	*Observation*
All diabetes-related health checks for each person with diabetes are up to date according to each person's own plan	*Observation, documentation*
Relevant tools (for example blood pressure monitor, healthy eating information) are available to support the staff to deliver high-quality care and these tools are maintained as appropriate.	*Observation, documentation and evidence of activity.*

Supporting information:

Podiatry Urgent Referrals
For any urgent podiatry issues refer via the emergency Podiatry line – 01209 318093 or email cft.podiatryhotline@nhs.net

Service referrals can be e-mailed to cft.cornwallpodiatryreferrals@nhs.net

NHS Choices Diabetes (https://www.nhs.uk/conditions/diabetes/)

Diabetes UK (https://www.diabetes.org.uk/)

NHS National Patient Safety Agency The adult patient's passport to safer use of insulin (https://www.sps.nhs.uk/wp-content/uploads/2018/02/2011-NRLS-1283-Insulin-Alert-2011.03-v1.pdf)

NICE

- NICE CKS Type 1 Diabetes (https://cks.nice.org.uk/diabetes-type-1)
- NICE CKS Type 2 Diabetes (https://cks.nice.org.uk/diabetes-type-2)
- NICE CKS NICE Insulin Therapy in Type 1 Diabetes (https://cks.nice.org.uk/insulin-therapy-in-type-1-diabetes)

- NICE CKS Insulin Therapy in Type 2 Diabetes (https://cks.nice.org.uk/insulin-therapy-in-type-2-diabetes)
- NG17 Type 1 diabetes in adults: diagnosis and management (https://www.nice.org.uk/guidance/ng17)
- NG18 Diabetes (type 1 and type 2) in children and young people: diagnosis and management (https://www.nice.org.uk/guidance/ng18)
- NG19 Diabetic foot problems: prevention and management (https://www.nice.org.uk/guidance/ng19)
- NG28 Type 2 diabetes in adults: management (https://www.nice.org.uk/guidance/ng28)
- CG173 Neuropathic pain in adults: pharmacological management in non- specialist settings (https://www.nice.org.uk/guidance/cg173)

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OPERATING STANDARD

Standard:	Risk of VTE in care homes.	
Number:	23	
Author(s):	Andrew McSorley Thrombosis Specialist Nurse RCHT Jan Varney – NHS Kernow	
Date:	May 2019	**Review date:** May 2020

Topic overview

Around 60,000 deaths a year in the UK are due to venous thromboembolism (VTE) with around 50-60% of these associated with hospital admission. Care home residents have a similar risk profile for hospital associated thrombosis however the epidemiology of VTE in care homes remains unclear and the VTE risk profile of UK care home residents has not been investigated. The findings report from the Dublin conference 2016 (Author institutions: University of Birmingham, University of Oxford) suggest care homes residents are at high risk of VTE yet there is very limited use of VTE prophylaxis in this patient group. While there are clear guidelines and recommendations in place to reduce the risk of VTE in hospital in-patients there are no such measures in place for care home residents.

Clinical bottom line:
Venous thromboembolism may present as deep vein thrombosis (DVT) or pulmonary embolism (PE) and is a challenging problem in older adults in care homes.

Deep vein thrombosis (DVT) is a clot which forms inside a vein commonly in the lower limb and may be asymptomatic or symptomatic (with leg pain or swelling). If DVTs are not treated promptly, the long term complication of post thrombotic syndrome (PTS) can occur leading to increased risk for later VTE development and increased treatment costs and mortality rates. In pulmonary embolism (PE), the clot embolises to the pulmonary arteries, causing shortness of breath, chest pain, haemoptysis, heart failure and even death. The symptoms of PE can be hard to detect and may be masked by the symptoms of other underlying cardiopulmonary conditions The pathogenic factors believed to be responsible for VTE are generally considered to involve vascular wall injury, hypercoagulable state and impaired circulation, collectively known as Virchow's triad, although the absence of one or more of these does not preclude the occurrence of VTE. Many individual risk factors can contribute to an overall increased risk of VTE. The symptoms of VTE are often subtle in older residents and since elderly residents have a relatively high tolerance for reporting pain these symptoms often go unreported. It is possible for patients to have no symptoms at all; this is known as a "clinically silent "event. Efficient prevention of VTE is a challenging task for residents in care homes as so many are immobile and wheelchair dependant and prevention of VTE may be a clinical concern for staff working in these long term facilities.

Commissioner requirements

The commissioners expects that all providers will deliver high quality care for all patients whilst monitoring their risk factors for the potential of VTE, initiating preventative/ proactive measures to prevent this occurring. In the absence of national guidance or specific assessment tools regarding VTE prevention in non-acute settings, providers are expected to monitor patients for any signs and symptoms of VTE at an early stage and get medical help as a matter of urgency.

Providers will

Monitor known risk factors for VTE :

- Immobility – bed bound, wheel chair bound. Leg exercises can reduce venous stasis and should be encouraged. Even patients who are bed-bound can usually still do regular, gentle exercises such as ankle circling or toe stretching. Elevate the foot of their bed or prop up their feet with a pillow to prevent their circulation from pooling. If the patient is confined to a chair, encourage them to exercise their lower legs by raising their heels, keeping their toes on the floor, and then lowering their heels again, ten times. Then raise and lower their toes ten times, keeping their heels on the floor. They need to do these exercises on a regular basis
- Previous DVT or PE
- Stroke
- Dehydration: ensure adequate hydration see operation standard 1.(Oral hydration)
- Recent surgery – particularly orthopaedic hip/knee, or abdominal surgery in cancer. These residents may be on extended prophylaxis treatment from discharge from hospital.
- Significant co-morbidities– cancer, heart disease, inflammatory bowel conditions.

Signs and symptoms of DVT and PE

- **DVT:** usually develops in the calf but may also form in the thigh or other deep veins with unexplained unilateral swelling, tenderness or pain. Sometimes despite these symptoms, no obvious DVT is found.
- **PE:** breathlessness, either suddenly or becoming gradually worse, chest pain which can be worse on breathing in. Slight fever, rapid heartbeat, cough with or without blood stained sputum and sudden collapse.

Quality indicators

There are no national assessment tools or guidance for the prevention /reduction of venous thromboembolism in care homes at the present time; hence emphasis for this particular operating standard is on awareness regarding VTE.

Supporting Information:

- Risk of Venous Thromboembolism in care home residents - Conference Dublin 2016 -Author Institutions: University of Birmingham, University of Oxford.
- NICE clinical guidance 89 London: Venous Thrombo-embolism in over 16’s reducing the risk of hospital acquired Deep vein thrombosis or pulmonary embolism) in patients admitted to hospital - National Institute for Health and Clinical Excellence

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OPERATING STANDARD

Standard: One to One in the Care Home Setting	
Number: 24	
Author(S): Rebecca Hicks	
Date: May 2019	**Review Date:** May 2020

Topic overview

NHS Kernow is responsible for commissioning consistent high quality care across the county. All requests for additional one to one care will be considered by NHS Kernow with accompanying clinical evidence at time of request.

NHS Kernow needs to ensure that the least restrictive practice is always the upmost consideration for all clients, whilst meeting their individual needs and that the one to one support is reviewed in a timely manner.

Commissioner requirements

The Commissioner expects that :

The care setting will ensure that care plans, treatment and support are implemented, flexible, regularly reviewed for their effectiveness, changed if found to be ineffective and kept up to date in recognition of the changing needs of the person using the service – please see further information in Quality Indicators.

The Provider must demonstrate:

- that requested commissioned additional care needs (one to one) are above and beyond the expectation (or requirement) of the registration of the care setting.
- the care setting registration is appropriate to the level of need of the Client.
- the identified additional needs can be met by input from Cornwall Partnership NHS Foundation Trust.
- behaviours exhibited will cause undue harm to self or others.
- additional staff for one to one will not be used to meet the staffing level within the care setting.

Exclusions:

- NHS Kernow is unable to commission additional one to one care for symptoms typical of the diagnosis of dementia
- NHS Kernow is unable to commission one to one care for falls prevention.
- NHS Kernow is unable to provide a transfer of one to one from acute/community hospital or other residential setting.

Providers will
- Contact Cornwall Partnership Foundation Trust (CPFT) case co-ordinator in the first instance to enable a full assessment of need to be completed. - Use NHS Kernow buyers team to procure one to one support if agency staff required. - Ensure that timely reviews are completed with CPFT care co-ordinator. - Provide robust care plans and clinical evidence for any additional care needs commissioned. - Inform CPFT staff of any changes in presentation which may allow a reduction in one to one care and to be least restrictive. - Be aware that all additional need (one to one) is a temporary measure. The expectation is that the care setting will be able to formulate a care plan to prevent or limit any harm possible.

Quality indicators	
A care plan will be required for each application.	The care plan needs to demonstrate individual and specific care needs related to the additional care need request: **Identified Need:** how this is need is presenting, behaviour, emotional requirements, description of relevant incidents. **Risk Assessment:** What are the risks to self, others, environment etc. How do you make the care as safe as possible. **Goal setting:** what do you want to achieve for the client. **Intervention:** purpose of the additional staff, how are they going to meet the client's needs, what interaction they are required to perform. How is this information going to be recorded. Who is going to be contacted if there are further concerns. **Outcome:** Date of next review. What interventions worked well, what was less effective. Identified triggers. Clients likes and dislikes. How the needs are going to be met in the future.