Betsi Cadwaladr University Health Board – 12 Required Actions

A Place to Call Home - A Review into the Quality of Life and Care of Older People living in Care Homes in Wales

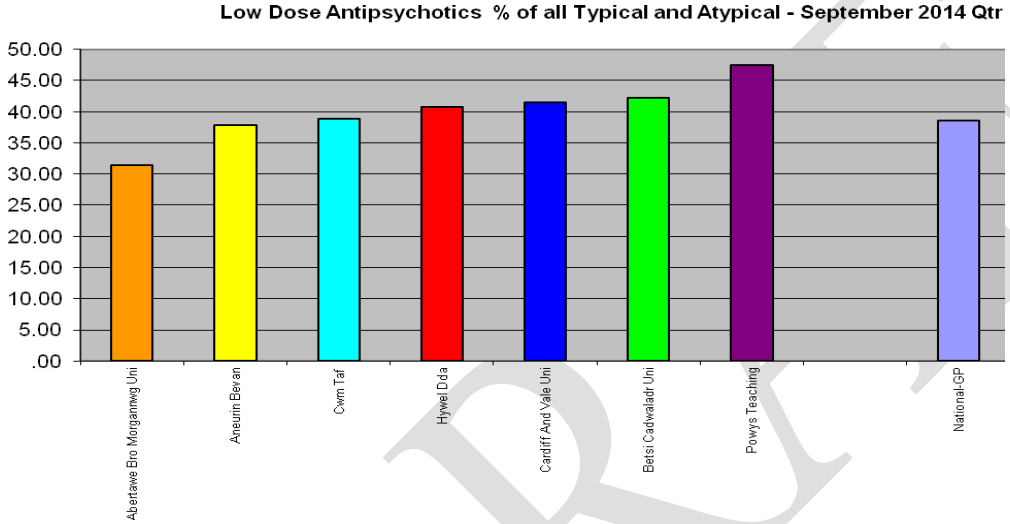
February 2015

Required Action 1	Current Position	Additional Action Required
1.3 Specialist care home continence support should be available to all care homes to support best practice in continence care, underpinned by clear national guidelines for the use of continence aids and dignity. **Target Date December 2015** (Welsh Government)	Specialist continence advice / support / intervention is available wherever the patient lives this includes care homes. If further investigation / treatment is required patients are referred directly to the appropriate consultant. Continence training is available for care home staff. Baseline continence assessments are undertaken by District Nursing Teams in Residential Homes who can access specialist continence support if needed. The All Wales Continence Bundle / Pathway triggers specialist continence input if required. The Practice Development Team monitors continence standards in nursing home and liaise with the continence service for specialist support.	Increased focus on the promotion of continence rather than the containment of incontinence by all staff involved in the care of the older person in care homes. Regular continence training specific to care homes, also to include e-learning. Promotion of the use of the All Wales Continence Bundle / Pathway in Care Homes or ensure continence documentation is fit for purpose. Further support for care home staff to achieve competencies. Each care home should have a policy that promotes continence and ensures access to specialist continence support when appropriate. Regular quarterly programme of audit is required of continence management in care homes with findings acted upon to improve standards of care. To explore the training and development of Band 3 Health Care Support Workers in community service to support continence work programme in care homes. Key actions in relation to the promotion of continence will be discussed with senior care home staff and the multi-disciplinary team (MDT). Review established led by the Area Nurse Directors to assess the current resources available within the community to support the increased and proactive work that is required to support care homes in the appropriate management of continence, rather than dealing with containment issues.

Required Action 2	Current Position	Additional Action Required
1.6 Older people are offered independent advocacy in the following circumstances: when a care home is closing; when a POVA referral has been made; when moving directly from hospital to a care home or from another care home as a result of safeguarding issues. For those with fluctuating capacity or communication difficulties, this should be non-instructed advocacy. When a care home is in escalating concerns, residents must have access to non-instructed advocacy. **Target Date** **April 2015** (Local Authorities, Care Home Providers)	Statutory Independent Mental Capacity Advocacy and Independent Mental Health Advocacy services in place across North Wales. The present position with regard to advocacy has been presented to the Health Board for the newly proposed Continuing Health Care Framework (CHC). <u>Advocacy</u> When a care home is closing: Draft policy for raising concerns is in development to include advocacy elements within this document. This includes procedure when and how to involve family and next of kin for ratification by April 2015 . • When a POVA referral has been made: Points to feature within the BCUHB raising concerns procedure will include: Who should invoke advocacy in respect of POVA and at which point. Written guidance for family to be included. • When moving directly from hospital to care home or from care home to another as a result of a safeguarding: Review underway of discharge policy underway with regard to advocacy services. • Moving from care homes as a result of safeguarding issue; Guidance already in place however further assurance underway to confirm the advocacy elements are made explicit by April 2015 led by the Deputy Director of Safeguarding.	BCUHB lead to be identified to complete (in conjunction with Regional Partners) a baseline assessment for non Statutory advocacy provision in commissioning and care home providers across North Wales by June 2015. Consultation and ratification of the procedures. Advocacy elements will feature in future contract or pre contract agreement to include the advocacy elements. Further clarification required in the National procedures and forthcoming Social Services and Well Being Act 2014. Resource and financial implication requirement to be identified. Development of a leaflet / guidance (multiagency) document to advise the public by June 2015. Adult Safeguarding Board to benchmark, review and implement as agreed within the revised Policies and procedures. Revision of the Health Boards Discharge Planning Policy to include this key element by June 2015. Complete review of the escalating concerns procedure by April 2015. Through the Joint Investigation Monitoring Panel and Home Operating Support Group the escalating concerns procedures need to capture and ensure that advocacy features appropriately throughout. Designated CHC and Safeguarding Leads to review the current Escalating guidance as outlined in WG Statutory Guidance May 2009. BCUHB are working with Local Authority (LA) to establish a baseline level of advocacy services across the region. LA has already commenced this scoping exercise across North Wales. It appears from scoping indicators that there are very limited agencies able to provide advocacy at the quality standard required. In North Wales a greater need for advocacy services has been identified in the West Region. .

Required Action 3	Current Position	Additional Action Required
2.2 Older people in care homes have access to specialist services and, where appropriate, multidisciplinary care that is designed to support rehabilitation after a period of ill health. **Target Date** **July 2015** (In partnership with Local Authorities))	BCUHB Nutrition and Dietetic services provide ongoing community support where appropriate for individuals discharged into care homes following hospital discharge. Liaison between hospital and community dietitians and the wider MDT is part of routine practice supporting integrated care. Occupational Therapy services provide ongoing support, as required, to residents in care homes on their discharge from hospital. In addition, patients who have not been admitted to hospital and reside in care homes can also access Community Occupational Therapy Services. Speech and Language Therapy (SLT) services provide ongoing support, as required, to residents in care homes on their discharge from hospital. In addition, patients who have not been admitted to hospital and reside in care homes can also access Community Speech and Language Therapy Services. Physiotherapy services provide ongoing support, as required to residents in care homes on their discharge form hospital. In addition people who have not been in hospital and reside in care homes can access community physiotherapy services. Access to Therapy services from care home dwelling is via referral from consultant or inpatient therapist on discharge or through GP or and other health and social care professional, via single point of access Single Point of Access (where operational) or through direct contact with the respective departments. On referral patients are triaged by a therapist and allocated to an appropriate therapist who on receipt of referral will liaise with the care home to organize appropriate assessment, treatment and ongoing care plan. Therapists are also involved in the education and training of care home staff to ensure residents receive appropriate ongoing care particularly in areas such as nutrition and manual handling.	Review of existing resources and further resources required to meet increased demand within the care home sector to ensure older people have access to specialist services. including

Required Action 4	Current Position	Additional Action Required
3.4 In-reach, multidisciplinary specialist mental health and wellbeing support for older people in care homes is developed and made available, including: An assessment of the mental health and wellbeing of older people as part of their initial care and support plan development and their on-going care planning. Advice and support to care staff about how to care effectively for older people with mental wellbeing and mental health needs, including dementia, and when to make referrals. Explicit referral pathways and criteria for referral. All residents on anti-psychotics are monitored and assessed for potential withdrawal and reviews are conducted in line with NICE guidelines. **Target Date November 2015**	The Health Board operates a local enhanced service with GPs for patients in care homes. This includes an initial face to face assessment within 14 days of admission to the care home. Face to face mid-year reviews of each patient and end of year health review is completed. Medication review and medication reconciliation are undertaken in discussion with a care home dispenser. Medication reviews are completed every six months. The review includes : Mental State Assessment: Mini Geriatric Depression Score Mini 6 point cognitive assessment Current Medical Problems Full system review Weight Diet Mobility Pressure area review Blood pressure Hearing Eyesight Osteoporosis risk assessment Immunisation history End of Life Care Plan All service users accessing care in a care homes providing nursing care receive a comprehensive assessment of needs in line with the National framework for CHC (Oct 2015). The resident will be reviewed by the Continuing health care team at 3 and 12 monthly intervals; the purpose of the review is to monitor and review the care plan and ensure that standards are being delivered in line with the care plan. All service users in care homes have access to the Older Peoples Mental Health Service; either through memory clinics or from within community mental health teams. Across some areas in BCUHB there are designated CPNs supporting care homes; including Dementia. In Line with National Minimum Standards for Care Homes; providers must ensure staff are adequately skilled and trained in dementia care; currently providers undertake their own training or some training is provided from the Local authority. CMHT referral pathway; some areas operate a first point of access with local authorities. Currently all Service users in care homes are reviewed by the GP as part of the enhanced service into care homes. Individuals on complex treatment regimes should be reviewed by NHS Consultant psychiatrist. Anti-psychotic medication will be reviewed as part of the twice yearly medication review. BCUHB guidelines are available to support review process Management Checklist for Behavioural Symptoms of Dementia Shared care agreement for acetylcholinesterases inhibitors donepezil, galantamine and rivastigmine Patients with dementia are also prioritised for holistic medication review within the Medicines management enhanced service to improve clinical effectiveness.	Development of service specification for dementia care to drive standards and quality improvement. To review the current support to care homes in terms of developing a complex needs service; with designated recourse. Develop further discussions with local universities to facilitate dementia care training. Develop a service specification for dementia care in care homes.

Required Action 5	Current Position	Additional Action Required
3.5 Information is published annually about the use of anti-psychotics in care homes, benchmarked against NICE guidelines and Welsh Government Intelligent Targets For Dementia. **Target Date September 2015**	Prescribing of antipsychotic medication is included within the All Wales Medicines Management Strategy Group therapeutic priorities and is a local comparator for Wales defined as - Low-dose antipsychotic items as a percentage of all typical and atypical antipsychotics. Quarterly prescribing data for each Health Board and GP practice is published to allow medicines management teams to focus work to reduce prescribing in high prescribing practices.  	Further ongoing review of monitoring anti-psychotic medication is required to support the ongoing work within the All Wales Medicines Management Strategy Group..

Required Action 6	Current Position	Additional Action Required
4.2 A formal agreement is developed and implemented between the care home and local primary care and specialist services based on the Statement of Entitlement. This should include: • Referral pathways, including open access • Waiting times • Referral and discharge information • Advice and information to support the on-going care of the older person in the home • Access to specialist services for older people in nursing homes, in line with the Fundamentals of Care Guidance. **Target Date** **April 2015** (Care home providers)	The Health Board only has a contract with those GP's who have signed up to the Directed Enhanced Service for Care Homes. DES for care homes established within North Wales since 2011. *refer to attachments for DES specification and guidance for GP practices 4.4. To date, we can confirm that 112 GP practices out of 114 have signed up to this enhanced service. Service requirements are within 14 days of admission –patient reviewed – thereafter 6 monthly and annual. (This covers residential and nursing homes). Frequency of visit is dependent upon clinical need. Medication review (in line with specification on 6, 12 months review). Payment processed and validated via Post Payment Verification (part of SLA between Primary Care Support Unit and Shared Services Partnership).	To work with local primary care contractors to develop more robust and formal systems to ensure older people who reside in care homes have equitable and responsive access to services developing measurable outcomes and targets. This work will commence April 2015. Annual audit within GP practices for care home interventions submitted but not routinely reviewed. Action during 2015/16 will be for the Health Board to strengthen this review to understand actual outcome based interventions provided within care home settings.

Required Action 7	Current Position	Additional Action Required
4.3 Care staff are provided with information, advice and, where appropriate, training to ensure they understand and identify the health needs of older people as well as when and how to make a referral. **Target Date** **November 2015**	Health needs will be identified via the nursing assessment within the Continuing Health Care process. Quality monitoring tool (QMT) is in place for all nursing homes. This is an annual audit by the Practice Development Nurse team (PDNT) on the fundamentals of care and identifies training and gaps. From this the relevant training, development and support will be implemented. The PDNT provide the homes with recommendations/guidelines on all current guidance/best practice/referral pathways. The nursing home staff access the practice development website, which has all the relevant guidance. Proactive reviews and visits are in place to maintain good relationships, partnerships and collaboration. PDNT provide support and recommendations that the homes use BCUHB documentation and pathways to strengthen referral processes. PDNT provide peer support to the matrons and are available for advice and support and develop leadership.	To support an equitable responsive access to specialist services within all care homes. Standardized access to training for all care homes across North Wales will be agreed. To include training and development, especially identifying the heath needs and early identification of symptoms and the effective management of older people. To include development of enhanced and advanced clinical support into care homes to provide clinical advice, support and training. BCUHB will strengthen links with universities to support the development of bespoke fit for purpose training and education for both Registered nurses and care staff. To further develop and improve admission and discharge processes between Nursing/Care homes and BCUHB led by Area Nurse Directors by November 2015.

Required Action 8	Current Position	Additional Action Required
4.4 Upon arrival at a care home, older people receive medication reviews by a clinically qualified professional, with regular medicine reviews undertaken in line with published best practice. **Target Date** **April 2015**	Medication reviews take place in line with the Direct Enhanced Service specification and included within the 6 and 12 months review. GP practices can sign up to a Direct Enhanced Service for care homes. This includes a review of the resident / patient on entering a care home and then a further two reviews every year which includes a medication review.	Review of the wider multi-disciplinary team to undertake medicine reviews to meet best practice guidelines.

Required Action 9	Current Position	Additional Action Required
5.6 A National Improvement Service is established to improve care homes where Local Authorities, Health Boards and CSSIW have identified significant and/or on-going risk factors concerning the quality of life or care provided to residents and/or potential breeches of their human rights. The national improvement team should utilise the skills of experienced care home managers, as well as other practitioners, to provide intensive and transformational support to drive up the standards of quality of life and care for residents as well as to prevent and mitigate future safeguarding risks. This service should also develop a range of resources and training materials to assist care homes that wish to improve in self-development and on-going improvement. **Target Date** **September 2016** (Welsh Government Lead in partnership with Local Authorities, Care Homes.	Continuing Health Care (CHC) teams review commissioned individual packages of care. QMT and CHC reviewers proactively identify gaps in clinical practice and educational needs with associated assurance and governance framework. PDNT respond to concerns highlighted by the QMT and share intelligence to put in place action plans to mitigate risks. Continuing Health Care (CHC)teams reviews of individual of patients. A monthly Clinical management groups to share intelligence including relevant actions and management. Joint proactive meetings with local authority to share intelligence. Monthly update report on all the homes under escalating concerns to the board. Regular quarterly matrons and managers of nursing homes forums. When homes are under formal escalating concerns process joint monitoring./visits and meetings take place. Nursing home agenda now on corporate risk register. POVA processes and CHC teams /safeguarding teams meet on a regular basis. Risks associated within care homes (in particular incident reporting) are reported via DATIX systems for BCUHB to review themes and actions. Regulation 38 notifications are reported to commissioners in the events of any significant events notification of death, illness and other events. Themes raised (in particular regulatory breaches or areas of risk) will be addressed by Nurse Review Team and Practice Development Team. Red Amber Green (RAG) Risk assessment is in place score in all nursing homes (in relation to Educational development/support) developed monthly, which informs quality and safety committee which is also escalated to the Executive Nurse Director.	To set up the development of a joint risk assessment between Local Authority and Health by December 2015. Utlisation of an audit process within care homes to measure quality of nursing care (including dignity in care) in line with Fundamentals of Care and Health Care Standards to build on the Quality Monitoring Tool development. BCUHB have developed an Escalating Concerns policy that aims to ensure appropriate processes are in place to raise concerns in relation to either quality of care or safeguarding issues within care homes. Full implementation required. The commissioning hub needs to support and coordinate across all care and nursing homes. Strengthen existing process to identify and manage risks and risk factors in order to drive up quality standards of care and mitigate associated risks.

Required Action 10	Current Position	Additional Action Required
6.2 Care home providers, commissioners and CSSIW should develop informal and systematic ways in which to ensure they better understand the quality of life of older people, through listening to them directly (outside of formal complaints) and ensuring issues they raise are acted upon. Annual reporting should be undertaken of how on-going feedback from older people has been used to drive continuous improvement. **Target Date** **April 15** (Care Home Providers, Local Authorities, CSSIW)	CSSIW and Local Authorities undertake quality control audits; The Health Board is not aware of systems in place to gain the residents feedback with regard to their experiences.	Review of current audit work taking place and to identify where feedback reports are shared. Implement principles of All Wales Framework for Assuring Service User Experience in nursing homes where the health board commissions services. To include:- Patient or carers Stories, comment cards and surveys in care homes. Utilise the All Wales Fundamentals of Care Audit Tool which captures service user feedback Establish in partnership a Residents Experience Group by June 2015. Incorporate within the Service Users Experience Annual Report for the Board.

Required Action 11	Current Position	Additional Action Required
6.8 Health Boards include the following information relating to the quality of life and care of older people in residential and nursing care homes in their existing Annual Quality Statements: the inappropriate use of anti-psychotics access to mental health and wellbeing support access to falls prevention access to reablement services support to maintain sight and hearing Further areas for inclusion to be developed as part of the AQS guidance published annually. **Target Date** **September 2015**	The identified areas for inclusion were included in the Health Boards Trusted to Care review which included Nursing Homes. Practice Development Nursing Team in conjunction with Public Health Wales has developed a Nursing Home Falls Pathway. This pathway is supported with training to support nursing homes. Within the Quality Monitoring Tool, falls is a domain and as such identifies practice gaps which the team will respond to. The Practice Development Nursing Team will advise nursing home staff to call specialist nursing/therapists/medical attention as required. The team link closely with the medicines management teams to provide ongoing support training and monitoring for the homes. The Medicines Administration Record charts are audited under the regular Quality Monitoring Tool audit for correctness.	The Health Board is exploring whether this is appropriate to be included in the Annual Quality Statement (AQS). We feel it needs to link with the all Wales work on the metrics relating to older people, and needs an All Wales and Regulatory approach going forward. The Interim Director of Quality Assurance to work with others to broaden the content of the AQS to provide a broader focus on provided and commissioned care.

Required Action 12	Current Position	Additional Action Required
7.3 The NHS works with the care home sector to develop it as a key part of the nursing career pathway, including providing full peer and professional development support to nurses working in care homes. **Target Date** **March 2016**	The Practice Development Nursing Team provide peer support, clinical advice, professional development and leadership to all the nurses within nursing homes in North Wales. The team offer guidance on training and available academic development and reinforces accountability and delegation processes. The Health Board supports the nurse lead for education to develop student nurse placements within the nursing homes working with the universities to identify required bespoke training and development modules. The Practice Development Nursing Team respond and refer to NMC when and if needed and promote the importance of the right nursing skill mix and fit for purpose staff with recognized competences.	As part of the transformation of services in North Wales further work is required to reach all care homes within North Wales to develop them as a key part of the nursing career pathway, This will need to include resources to support full peer and professional development to nurses working in care homes.