SCHEDULE 2A – CARE HOME SPECIFICATION

1. Aims and Objectives of the Care Home Service

The aim of the Care Home Service is to ensure people in Cornwall have access to good quality care, support and accommodation that can enable them to meet their health and social care needs and outcomes twenty-four hours a day, 365 days a year.

The Care Home will provide Services with or without nursing for a Person who is eligible in accordance with:

a) The Care Act 2014
b) The eligibility criteria for NHS Funded Nursing Care or Continuing Healthcare
c) Other joint funding responsibilities of the Commissioners.

The Care Home Provider will provide care and support in accordance with:

- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as monitored, inspected and regulated by Care Quality Commission to ensure Care Home Services meet fundamental standards of quality and safety
- The Health and Safety at Work etc. Act 1974 and the Management of Health and Safety at Work Regulations 1999
- The quality requirements included in this Service Specification and referred to in Schedule 4A and 4C of this Contract.

The Care Home Provider will also observe the principles of national and local good practice and clinical guidance, including but not limited to the appropriate NICE guidelines, quality standards, pathways and local authority briefings.

2. Strategic Outcomes

The Care Home Provider will endeavour to support Commissioners in achieving the outcomes set out in the Outcomes Frameworks for Adult Social Care, Public Health and the NHS, specifically:

2.1 Adult Social Care Outcomes Framework:

a) Enhancing the quality of life of people with care and support needs
b) Delaying and reducing the need for care and support
c) Ensuring that people have a positive experience of care and support
d) Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

2.2 Public Health Outcomes Framework:

a) Increased healthy life expectancy
b) Reduced differences in life expectancy and healthy life expectancy between communities.

2.3 NHS Outcomes Framework:

c) Preventing people from dying prematurely
d) Enhancing quality of life for people with long-term conditions
e) Helping people to recover from episodes of ill-health or following injury
f) Ensuring people have a positive experience of care

g) Treating and caring for people in a safe environment and protecting them from avoidable harm.

During the Contract Term the Commissioners may review information to evidence how outcomes have been achieved by the Care Home, including but not limited to:

- Outcome of the Person's review
- Monitoring of Performance Indicators
- Contact Review Meetings
- Monitoring of trends arising from safeguarding
- Quality Assurance reporting
- Feedback and response to feedback from Residents, Relatives and Staff Care Home Provider's compliments and complaints log and response
- CQC inspection and reporting documents
- Business plans and other relevant documents
- Other information the Commissioner may reasonably request from time to time.

2.4 Care Home Services are a key partner in achieving the health and social care outcomes and will work in partnership with relevant services to achieve these locally.

3. Personal Outcomes

In providing the Care Home Service the Care Home Provider will meet the Person's Eligible Needs as set out in their Care and Support Plan and in accordance with the requirements of the Regulations and this Service Specification. This is in the recognition that the Service Specification sets out all requirements for the provision of Care Home Services, some of which may or may not apply to the care and support needs of individual Residents.

The Care Home will support the Person to maximise their potential to live an active and fulfilling life by achieving their own personal goals, reaching and maintaining their optimal health and promoting the Person's independence and wellbeing within their individual limits and capabilities, which also applies throughout this Service Specification.

Each Person, with the support of the Person's Representative if appropriate, will be central to all aspects of their care and support.

4. Principles of Care

4.1 The Care Home Provider will ensure the Service is provided in a manner that meets the following principles of care:

a) **Person Centred Care:** The Care Home Provider will ensure the Person has their care and support provided so that it meets their identified Eligible Needs, in accordance with their person-centred Care and Support Plan. This is to include social needs, including meaningful activities. The Care Home Provider will ensure the Person's health needs are met either through direct provision of nursing or joint working with commissioned health services, in accordance with the status of the Care Home's registration.
b) **Quality of Life and Independence:** The Care Home Provider will enable the Person to maximise their quality of life, wellbeing and independence and to undertake aspects of their own care for as long as they are able and willing to do so.
c) **Dignity and Respect:** The Care Home Provider will treat the Person with dignity and respect at all times. They will ensure the Person feels valued as a unique individual whatever their abilities and will not have their rights and choices restricted due to the practices of the Care Home Provider
d) **Safeguarding:** The Care Home Provider will ensure there are appropriate systems and processes in place to safeguard the Person from harm, abuse and neglect in accordance with the local safeguarding policies and procedures and the requirements of this Contract
e) **Choice and Control:** The Care Home Provider will ensure the Person is involved in all decisions affecting their own life and daily living, with the assumption they are able to make their own decisions unless there is clear evidence that they are unable to do so,

in accordance with the principles of the Mental Capacity Act 2005

f) **Right to Privacy:** The Care Home Provider will ensure the Person's right to privacy is observed and that their belongings and their affairs are respected at all times

g) **Equality and Diversity:** The Care Home Provider will ensure the Person has equal access to Care Home Services, that their individual diversity, values and human rights are recognised and upheld and that they are not to be discriminated against on the grounds of those characteristics protected under the Equality Act 2010

h) **Social Networks:** The Care Home Provider will ensure the Person is actively encouraged to engage with their social network including but not limited to friends, family and others in their own community, offering opportunities both inside and outside of the Care Home as well as utilising social media and other technology based solutions.

i) **Activities:** The Care Home Provider will ensure the Person is proactively enabled and encouraged to engage in stimulating and meaningful activities, including those that are person centred to them and other interactions regularly, each and every day

j) **Community Facilities:** The Care Home Provider will enable the Person to access facilities and services in the community in accordance with their Care and Support Plan

k) **Compliments, Comments and Complaints:** The Care Home Provider will ensure the Person is supported to make compliments, comments or complaints about the care and support they receive or about any other aspect of the Care Home Service, in the knowledge that they will be accepted in a positive light and used, along with other means of assessing the quality of the care provided, to improve the Care Home Service currently being delivered.

l) **Coproduction:** The Care Home Provider will instil the principles of Coproduction in appropriate aspects of the Care Home service, actively involving Care Home Residents and their families, Staff and other Stakeholders identified by the Care Home Provider in a range of opportunities to participate in and influence the running and development of the Care Home.

m) **Partnership:** The Care Home Provider will ensure the Care Home is part of the wider integrated health and social care services, working with other professionals including but not limited to GPs, consultants, primary health teams, acute health services, specialist health services, social workers, occupational therapists, physiotherapists, community mental health and nursing teams, the voluntary and community sector and other independent Care Home providers.

4.2 In observing the principles of care the Care Home will work to those set out in the NICE guidelines www.nice.org.uk , quality standards and pathways including, but not limited to:

- Long–term conditions
- Dementia pathway
- Care for adults with depression
- Managing medicines in care homes
- Mental wellbeing for older people
- Nutrition support in adults
- Falls prevention in older people
- Prevention and control of healthcare associated infections
- End of Life Care for adults (Quality Standard 13)
- Oral health in care homes (Quality Standard 151)

4.3 The Provider shall ensure that referrals by the Care Home on behalf of the Person to primary and community health care services , are made as soon as reasonably practicable and are followed up when a referral is not accepted or actioned.

5. Care Home Delivery Requirements

5.1 General Requirements

The care, support and accommodation provided by the Care Home must be at all times in accordance with the principles and requirements stated in this Service Specification and the Regulations of the Care Quality Commission. The Care Home Provider must ensure:

a) A copy of this Contract is available to Staff on request.
b) The Registered Manager and any deputies are able to demonstrate that they have a full understanding of the requirements relevant to their role.
c) Staff will be able to demonstrate, to a level that is proportionate and appropriate for their role, knowledge of the CQC Regulations. This will include an understanding that they are accountable for maintaining and delivering good quality care and support including but not limited to Person centred care, management of falls, nutrition, hydration, infection control and end of life care.
d) A designated competent and appropriately skilled leader is always on duty
e) Staff are able to respond to requests for care and support at all times, ensuring any assistance requested by the Person is provided as soon as possible ensuring that the Person is not left at risk, in distress or without care that meets their health and wellbeing needs. This includes but is not limited to responding to call alarms.
f) Adequate time for effective handover between shifts, which is proportionate to the complexity of need and number of Residents and there is evidence that handovers have taken place
g) The overall risk and dependency levels of existing Residents living in the Care Home are considered in determining the compatibility of a new Person for a placement at the Care Home
h) Facilities, equipment and provisions needed to provide the Care Home Service in accordance with the Regulations and this Service Specification are provided by the Care Home and are appropriately available in accordance with the *Provision of Equipment in Care Homes Policy 2020*.

5.2 Care Home Facilities and Services

The Care Home must provide the Person with:

a) A single room, unless the Person wishes to share
b) Appropriate, well maintained accommodation that offers the Person opportunities to:
   - Access the garden and outdoor spaces
   - See and look after their visitors
   - Engage in meaningful activities
   - Spend time together with others and time alone.
c) Appropriate toilet and bathing facilities that enable the needs of the full range of Residents to be met
d) Full board, including varied and nutritionally balanced meals, snacks and drinks at meal times or at any other time of the day or night, including opportunities for the Person to choose an alternative meal if they wish
e) Personal care, in accordance with the Person's Care and Support Plan
f) Nursing care where the Care Home is registered as a Care Home with nursing or access to community nursing provided by the NHS if the Care Home is registered as a Care Home without nursing
g) Staffing provided at an appropriate level to ensure the individual Person and all Residents' care and support needs are met in accordance with their Care and Support Plans.
h) Access to range of meaningful activities that are person centred and promote wellbeing in accordance with the person's Care and Support Plan.
i) Access to full laundry including all bed linen, towels and personal clothes. The Care Home will make no extra charge to the Person for doing any of their laundry, other than specialist dry clean only items.
j) A Welcome Pack including but not limited to information about safeguarding, complaints/compliments (including escalation to the commissioner, regulator or ombudsman), additional service charges, information about financial eligibility for services and any specifci expectations on the Resident.

5.3 Care Requirements

Managing and maintaining nutrition: The Care Home will ensure meals are well balanced, varied and nutritious, offering the Person a choice of meal on a daily basis. A varied menu

choice will be Coproduced with Residents wherever possible and reviewed no less than quarterly.
Maintaining Personal Hygiene: The Care Home Provider will ensure Staff give the appropriate degree of assistance, as requested or required, in accordance with an acceptable standard of hygiene and the Person's Care and Support Plan**.**

The Care Home will observe the principles of the NICE Guidelines for Oral Health and ensure Staff are trained in the promotion or oral hygiene and dental care. Staff will strive at all times to support the Person to prevent and address any mouth ulceration, dental decay and other mouth and gum conditions contrary to health. This will include access to dentist and hygienist care outside of the care home if appropriate.

Managing toilet needs: The Care Home Provider will ensure the Person has the opportunity to use the toilet when they wish, with Staff providing the appropriate degree of assistance, as requested or required in accordance with their Care and Support Plan**.** All care and support is provided in accordance with the NICE guidance, ensuring full privacy and dignity is maintained at all times.

The Care Home Provider will ensure all relevant policies and procedures for toileting and continence care are in place and that Staff are fully aware and appropriately trained. Where the Person has been assessed as requiring continence products these will be supplied by the commissioned supplier authorised by community nursing or NHS Kernow heath team using the county wide continence product formulary and in accordance with the Cornwall Partnership Foundation Trust and NHS Kernow eligibility criteria.

Maintaining a habitable home environment: The Care Home Provider will encourage the Person to personalise their room. This includes bringing their own furniture and personal possessions, providing the physical condition of these possessions meets with the reasonable approval of the Care Home and do not constitute a health and safety risk. Details of any property brought into the Care Home by the Person will be accurately recorded on admission.

The Care Home will ensure the Person can choose to have access to a television, telephone and internet in their own bedroom. This will be at the person's request with all additional costs of installation and ongoing charges at the Person's expense.

Where a Home has facilities for services or activities not directly related to the Care Home Residents, which may include but is not limited to the delivery of day care services, the Care Home will:

a) Ensure they are organised and located so that they do not negatively impact on the lifestyle, wellbeing or safety of the Care Home's residents
b) Involve the Care Home Residents in decisions about these activities
c) Allow Care Home Residents the opportunity to join in with these additional services, providing that the care for those either attending or living in the Care Home is not compromised. Care Home Residents will be able to attend any day services provided from the Care Home in which they are resident at no additional cost.

Developing and maintaining family or other personal relationships: The Care Home Provider will endeavour to ensure the Person is supported to build and maintain relationships including seeing their family and friends, taking part in their local community, both within the home and outside and enabling their participation in important occasions.

Communication: The Care Home Provider will ensure Staff have the communication skills and training required to carry out their role. This may include speech or a variety of augmentative communication aids including but not limited to picture boards, computerised talk boards, sign language and Makaton in accordance with the Person's needs and their Care and Support Plan. The Service Provider will ensure Staff comply with the national standards for accessible communication.

Activities and Accessing the Local Community: The Care Home Provider will ensure Staff take the time to understand the Person's skills, experiences and interests and use this

knowledge to enhance their Care and Support Plan by creating meaningful, person centred activities. This may include but is not limited to taking part in work, training, education, volunteering and other activities.

Where the Person has dementia, learning disabilities or other complex care needs, the Care Home will offer a range of therapeutic activities. Staff should be trained to enable appropriate development, planning and implementation of such activities. These activities may form part of the Person's Care and Support Plan to minimise agitation and support distraction therapy techniques.

Attendance at Day Services: Where the Person attends an outside Day Service that is not part of the Care Home this will usually be arranged by the Commissioner and included in the Person's Care and Support Plan.

Where the Person requires one to one care and support during their time at the Day Service, the Care Home Provider may be asked by the Commissioner to provide Staff to attend the Day Service with the Person to ensure they are supported throughout the day. Where this applies, the requirements for the Care Home will be clearly described and included in the Person's Care and Support Plan and included in the cost of the Placement.

Where the Person attends an outside Day Service, the Care Home Provider may be asked to arrange the Person's transport. This may include making an escort available. Where this applies, the requirements for the Care Home will be clearly described in the Person's Care and Support Plan and funded in accordance with the Council's *Policy for Transport Arrangements*.

All arrangements for Day Services will be made in accordance with the Person's individual Care and Support Plan.

In circumstances where the Care Home is directly arranging and funding a Day Service placement for the Person and the Day Service placement is not attended by a member of the Care Home Staff, the Care Home Provider will only arrange this in accordance with the requirements of the Contract for subcontracting and will be responsible for all aspects of this alternative care including:

a) That the alternative service is able to meet the Person's eligible care needs
b) Assurance of quality
c) Arranging Transport.

Being able to fulfil their role as a parent: The Care Home Provider will ensure, where the Person is a parent of a Child under the age of sixteen, they are supported to have contact with their family in accordance with their wishes and their Care and Support Plan. The Care Home will maximise the Person's involvement as a family member including the availability of rooms where the family can meet, including the Person's children, away from the communal area.

5.4 Care Planning

The Care and Support Plan is a living document. The Commissioner will be responsible for identifying the Person's care and support needs and developing a plan for their needs to be met. The Care Home Provider will review, edit and develop the Care and Support Plan to meet the identified needs and the effectiveness of the Care and Support Plan and its contents will be reviewed on an on-going basis. The Care Home Provider will maintain a record of Care and Support Plan reviews.

The Commissioner will use a multidisciplinary approach to develop the Care and Support Plan with the Person at the commencement of their Care Home Placement.

In agreeing to the Care and Support Plan the Care Home Provider is expected to meet all of the Person's needs included in the Care and Support Plan. The Care Home Provider will:

a) Within the first seven days following the Person's placement and on an ongoing basis

thereafter, enhance the Care and Support Plan utilising information included in the Person's Needs Assessment, their medical treatment plans and the Care Home's own assessment of the Person's needs. The Care Home Provider will clearly set out how they will meet the Person's Eligible Care Needs and outcomes and ensure this additional information is clearly recorded in the updated version of the Care and Support Plan. This will include information about the Person's mental capacity including their ability to make use of, or weigh information to make decisions and how the Care Home will support the Person in this. It will also include the outcome of any mental capacity assessment and associated Deprivation of Liberty authorisations.

b) Ensure any valid advanced decisions to refuse treatment and defined Best Interest Decisions stated in the Person's Care and Support Plan are adhered to, including Person's end of life wishes (if known) and Treatment Escalation Plan (TEP). Wherever a Best Interest Decision has been made, the Care Home Provider will continue to encourage the Person's participation in these decisions. The Care Home Provider will notify the Commissioner of any changes in circumstance, which may necessitate a review of the specific Best Interest Decisions.

c) Review the Person's care and support needs on an ongoing basis and no less than monthly, instigating a formal Review wherever the needs of the Person have changed to the extent that they require a change in the level or type of service provided.

d) The Care Plan will include a Risk Assessment record of risks to Carers, Care Workers, the Service User, and others persons associated with the care package. Risks may include (but are not limited to):
   - Risks from the care environment;
   - Safeguarding risks;
   - Risks related to Service User behaviour; and
   - Risk assessments for nutrition (Malnutrition Universal Screening Tool – MUST), pressure ulcers, falls etc.

   The Risk Assessment record also includes any specific requirements for managing and mitigating risks. It is the Care Home Provider's responsibility to review and update these risks within the Care and Support Plan review. The Care Home will agree the funding arrangements with the Commissioning Authority at the point of change and not with the care plan reviewer if they are employed by a different Commissioning Authority.

5.5 Health and Nursing Care

5.5.1 Health Care

The Care Home will actively promote the Person's health.

The Care Home will proactively and effectively support the Person to access the full range of NHS commissioned primary care, dental care, universal and specialist health support services, hospitals and community health services according to their need. Staff will discuss the service with the Person required to address any health concerns and refer on appropriately.

The Care Home will work in partnership with health services, social care services and voluntary services to build a strong supportive care plan around the Person so as to maximise health potential and focus on staying well.

All health related risks outside of the Person's Care and Support Plan will be assessed, monitored and well managed, with all concerns being effectively recorded, discussed, escalated and addressed in a timely manner. This may include emergency care requirements or urgent care from the Primary Health care team or community health services.

The Care Home will ensure the Person has access to any required health checks, including but not limited to the dentist, GP and optician. This will be undertaken no less than annually.

The Care Home will ensure it has a policy for managing any deterioration of the Person's health and will actively seek appropriate medical advice to maintain the Person's safety whilst

assisting to reduce the risk of avoidable hospital admissions. The Care Home Provider will consider the use of National Early Warning Score (NEWS2) in managing deterioration.

Red Bags: In areas where the 'red bag' scheme is operational and where the Person is admitted to hospital, the Care Home will comply with the 'red bag' scheme, providing information and personal belongings as determined by the scheme. The Trusted Assessor and other NHS staff will work with the Care Home to ensure the 'red bag' is returned with the Person at the point of discharge. If the Person returns to the Care Home from hospital without their 'red bag' or associated contents, the Care Home will work with the Trusted Assessor to retrieve the items. The Care Home will take responsibility for retrieving any non-returned items from the hospital.

5.5.2 Nursing and other health care

Where the Care Home is providing nursing care for the Person, the Care Home Provider will ensure the availability of a qualified nurse on site 24 hours a day. Care Homes with nursing will provide care for the Person where:

a) Their primary need is for accommodation and social care, but have a nursing need which requires 24-hour availability of a registered nurse
b) Their primary need is for accommodation and nursing care.

Nursing care will include but is not limited to:

a) Direct nursing tasks required to meet a person needs
b) Assessment, planning, supervision and monitoring of Residents health care needs and delivering appropriate nursing care.
c) Recognising preventable or reversible medical conditions and the changing dependency of the Person's condition
d) Offering nursing interventions in health care and treatment plans including infection control, wound management, continence care, pressure area care, oral care and care of the person with dementia and end of life palliative care under the direction of primary or secondary or emergency health services.

The Care Home will ensure all nursing Staff hold up to date registration and revalidation status with the Nursing and Midwifery Council (NMC) and has a checking process in place to provide further assurance.

The Care Home will ensure nursing Staff are compliant with NMC Code of Conduct, the professional standards that nurses must uphold in order to be registered to practise in the UK.

Other allied health professionals who are employed by the Care Home Provider and working in the Care Home must be registered with the Health and Care Professions Council.

The Care Home Provider will ensure that timely onward referrals are made to specialist services in the event of any significant change in the Person's condition and informing the Person's Representative and next of kin, as appropriate.

5.6 Dementia Care

The Care Home will ensure:

a) All care and support is provided within the legal requirements of the Mental Capacity Act (2005) and Mental Health Act (1983 and 2007), including Deprivation of Liberty and Safeguards
b) All care and support provided for Residents with dementia is delivered in line with NICE Guidance.
c) Staff have a knowledge and understanding of signs and symptoms of long standing/chronic/severe dementia and that they alert the community health teams to

that effect to ensure a diagnosis is made, and that this is documented clearly in the Person's Care and Support Plan, and communicated clearly at each transition of care

d) Staff working with Residents with dementia are trained to communicate effectively with people with dementia
e) The Care Home Provider is working towards ensuring the Care Home environment is consistent with the best practice on creating a dementia friendly environment.
f) The Person's Care and Support Plan includes activities of daily living that maximise independent and individual activity, enhance function, adapt and develop skills and minimise the need for support wherever possible. The Care Home will be responsive to the Person's individual needs, provide choice and facilitate the Person's ability to make decisions about their care.
g) Each Resident that experiences behavioural and psychological symptoms of dementia is referred to the GP to consider a specialist assessment. The formulation of the Person's Care and Support Plan will detail the non-pharmacological interventions for behavioural and psychological symptoms of their dementia to aid in a reduction in the use of antipsychotic and other medication.
h) Consideration of technology to assist the Person with dementia to gain a more fulfilling quality of life.

5.7 End of Life Care

The Care Home Provider will plan, deliver and design End of Life Care in accordance with the 6 Ambitions for Palliative and End of Life Care (2015-2020) local and national policy. http://endoflifecareambitions.org.uk/

The Care Home Provider will facilitate close liaison with the appropriate professionals to ensure:

a) Where appropriate, the Person has an appropriate End of Life Plan, Treatment Escalation Plan (TEP), Advanced Care Plan in place at the earliest opportunity to enable them to be supported to live well until the end of their life and die well in the place of their choosing. This must be signed by the GP or palliative care consultant nurse.
b) The Person's clinical needs are assessed in a holistic and dignified manner, demonstrating the use of appropriate advanced care planning or care needs assessment which may be a specific care planning tool or end of life care plan.
c) The Person receives appropriate symptom and pain relief when required and without delay.
d) Where the Person lacks capacity, the Care Home will facilitate a Best Interest meeting, ensuring care is delivered in accordance with section 4 of the Mental Capacity Act (2005).
e) Where the Person has an End of Life Plan, the appropriate care and support is implemented in the last days of their life as described in the plan, wherever possible.
f) The Person is treated with dignity and respect, in familiar surroundings and in the company of close family and friends in accordance with their wishes.
g) The Person's religious and spiritual needs are respected and support is given to ensure these needs can be met.

The Care Home Provider will ensure all Staff are appropriately and adequately trained to ensure that:

a) The Person is communicated with in a dignified and private environment with their family, or significant people around them.
b) All Staff have been provided with training and are aware of the difference between Advanced Care Plan, Treatment Escalation Plan or End of Life Plan.
c) Any Advanced Care Plan, Treatment Escalation Plan or End of Life Plan is communicated in such a way as to support the Person in understanding they have a palliative health condition with a deteriorating condition that is life limiting.
d) It is recognised when the Person is approaching or at the end of their life.
e) There is effective communication with the Person and all relevant professionals in a multidisciplinary approach to achieve good end of life care.

f) That the Person is **not** admitted to hospital if that is against their wishes and there is no medical need for acute intervention.

5.8 Medication

5.8.1 General

The Care Home Provider will ensure the Person is supported to take their medication in a manner that is safe and appropriate to their needs and preferences.

The Care Home Provider will have a formal written policy and procedure on medication management, which is prepared in accordance with the Royal Pharmacological Society guidelines, current NICE guidelines for best practice and Nursing and Midwifery Council guidelines. The Care Home will have an agreement in place with their Pharmacy to provide information, advice and guidance and to audit the Care Home's management of medication in accordance with the CQC regulations, legal requirements and good practice.

5.8.2 On Arrival at the Care Home

The Care Home will endeavour to ensure that the following information is available for medicines reconciliation on the day the Person arrives at the Care Home:

a) The Person's details, including full name, date of birth, NHS number, address and previous address
b) GP's details and other relevant contacts defined by the Person and/or the Person's Representative, including but not limited to any consultant, regular pharmacist and specialist nurse. The Care Home Provider will check the Person is registered with a local GP upon commencement of the Placement. Where the Person is not registered with a local GP the Provider will arrange this.
c) Known or suspected allergies and intolerances to medication or ingredients and the type of reaction experienced
d) Medicines the Person is currently taking (prescribed and purchased), including name, strength, form, dose, timing and frequency, how the medication is taken (route of administration) and what the medication is for, if known
e) Changes to medication, including medication started, stopped or dosage changed, and reason for change
f) Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day, including weekly or monthly medicines as far back as the last dose administered
g) Other information, including when the medicine should be reviewed or monitored and any support the resident needs to carry on taking the medicine.
h) Any support that the Person requires to enable them to continue to use their medicines.

If, for whatever reason, this information has not been made available at the point of a hospital discharge, the Care Home will ensure this is escalated without delay to ensure this information is available as soon as possible.

5.8.3 Medication Review

Every Person taking medicines should have a regular medication review. The interval between these reviews will be determined by health and social care practitioners, based on the needs of the individual. Intervals may differ between Residents. Medication reviews should be completed at least annually.

The Care Home will ensure that medication reviews involve the Person and/or the Person's Representative and a local team of health and social care practitioners, as appropriate.

5.8.4 Medication Safety

The Care Home will ensure a well-developed culture of safety is implemented to protect the Person from harm that can be caused by medication to include the following. The Care Home will:

a) Provide a Medication Administration Record (MAR) for Staff to complete. This will include a recent colour photo of the Person and their name.
b) Ensure Staff who are providing Residents with assistance to take medication, record the details of medication taken, time and dosage on the medication administration record.
c) Provide training appropriate to the role of Staff with regard to the handling of medications used by the Person.
d) Ensure medications are stored in a suitable secure place that is not affected by extreme heat and moisture and at the appropriate temperature.
e) Request a review of the Person's medication by an appropriate health care professional as and when required and not less than an annual basis.
f) Ensure well established links with the GP and Community Pharmacy for appropriate advice and support.
g) Check the medication against the medication administration chart prior to administration and recording accurately.
h) Implement infection control procedures during the administration of medication
i) Regularly audit administration charts, controlled drugs records, disposal records, and stocks including fridge temperatures, expiry dates and dates of opening on short life medications.
j) Ensure alerts, reminders, posters and facilities which enable Staff and the Person to follow the correct procedures for managing medication.
k) Ensure sufficient Staff and procedures that allow the administration of medication within a short period of time with minimal distraction.
l) Have in place a well-established procedure for reporting, analysing and learning from incidents, errors and near misses in relation to medication management.
m) Have in place a culture of reflective practice to enable Staff to learn from errors
n) Ensure that all medicine related safety incidents including all 'near misses' and incidents that do not cause any harm to a person's safety are recorded.
o) Ensure there is a policy in place and implemented for the ordering, receipt, administration, and storage and Destruction of Controlled Drugs and that this policy includes the reporting of incidents that involve controlled drugs including reporting to the Controlled Drugs Accountable Officer, NHS England.
p) Where there are notifiable safeguarding concerns, ensure these are reported to CQC. Also refer to Schedule 2K of this contract.
q) Refer to information pertaining to medicines management in care homes found in NHS Kernow *Medicines Management Framework for Care Homes*. This may be accessed via the Cornwall Joint Formulary https://www.eclipsesolutions.org/cornwall/

5.9 Infection Prevention and Control

The Care Home Provider will:

a) Identify a named lead who will take responsibility for Infection Prevention and Control and Decontamination
b) Ensure there are simple, up to date policies, procedures and processes relating to the prevention and control of infection and that all Staff are able to demonstrate knowledge and operational compliance.
c) Develop their policy and procedure in accordance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and all related guidance. Include the provision and correct use of Personal Protective Equipment, decontamination of equipment and waste disposal.
d) Ensure that all Staff are trained to work safely with the Person at all times.
e) Ensure all Residents are vaccinated against influenza in line with NHS guidelines and their personal choice. Ensure that all Staff are proactively encouraged to vaccinate themselves against influenza
f) Put in place the necessary emergency plan to respond to any infection or disease outbreaks including but not limited to norovirus and ensure early detection and

reporting of outbreaks.

g) Report any incidents to CQC, Public Health England and other relevant public health authorities.

5.10 Tissue Viability

5.10.1 The Care Home Provider will:

a) Ensure all care and support is provided in accordance with the local and national policies.
b) Ensure high quality tissue viability care for the Person and follow current national guidance regarding pressure ulcer prevention.
c) Evidence that Staff are competent and skilled to treat and/or manage pressure area care and treatment plans as required according to expectations and role and the individual needs and conditions of the Person
d) Ensure Staff are trained in the promotion of tissue viability and prevention of pressure ulceration or skin breakdown. Where pressure area breakdown exists the Care Home will ensure the local policies are followed.
e) For Care Homes with and without nursing, equipment to prevent pressure ulcers from development will be funded in accordance with the requirements of the *Provision of Equipment in Care Homes Policy*
f) Utilise a risk assessment to determine the Person's risk of developing pressure ulcers, ensuring effective prevention wherever possible. For Care Homes without Nursing, the Care Home will escalate any concerns to the Community Health team for effective treatment and seek guidance from a district nurse. For Care Homes with Nursing, the Care Home will ensure a risk review is completed weekly and monitored and reviewed as part of the care plan review at least monthly unless a change occurs between reviews. The Care Home will increase the frequency of reviews as determined by the level of mobility and other risk factors in the person centred Care and Support Plan.
g) Ensure that whenever a Person has a grade 1 or 2 pressure area it is treated or referred for treatment and actions are taken to reduce the risk of further breakdown including increasing moving and handling and re positioning schedules alongside nutritional and continence management improvements.
h) Ensure that whenever a Person has a Grade 3 or Grade 4 pressure ulcers, they are immediately referred to the Community Nursing Team and/or Community Health Tissue Viability service and report to Care Quality Commission, and NHS Kernow by emailing the detail to email address – kccg.SI@nhs.net.

5.10.2 Tissue Viability Equipment

Referrals made to the Community Health Tissue Viability Service as in point 5.10.1(g) above may result in the need for pressure relieving equipment once a clinical assessment has taken place. As this equipment is required for treatment purposes then NHS Kernow funds the rental. The equipment may be a dynamic mattress or cushion, or both.

Following receipt of a referral the Tissue Viability Service team will undertake the clinical assessment and if pressure relieving equipment is required the Tissue Viability Service team will request this through NHS Kernow Health Buyer Team who will place the order with the supplier. Equipment will be provided for a specified treatment period, which can be reviewed and extended as agreed by the Tissue Viability Service team. Once the delivery and installation is arranged the Care Home Provider will receive a rental agreement letter from NHS Kernow Health Buyer Team for signature and return. This letter sets out the requirements on the Care Home for managing the equipment.

5.11 Falls Prevention

The Care Home Provider will have a falls policy in place that includes the requirement to have:

a) A falls risk assessment where required.

b) Specific information on supporting the Person if they have fallen.
c) Safety measures to prevent falls.
d) How Staff should report any falls experienced by the Person, including where the Person is harmed as a result of the fall.
e) Specific falls prevention training.
f) Incident reporting and trend analysis of falls within the service.

5.12 Equipment

The Care Home Provider will at all times, at its own cost, ensure the availability of any equipment necessary to provide Services that promote the independence, safety and mobility of the Person, in accordance with the Council and NHS Kernow's Provision of Equipment in Care Homes Policy 2020.

The Care Home Provider will at all times comply with the Law (including Health and Safety Regulations / Health and Social Care Regulations) and any applicable quality and performance indicators in relation to the environment and the equipment used, and will ensure that they are clean, safe, suitable, adequate, functional and effective, and fit for the purpose of providing the service. The Care Home Provider will store, use and maintain all equipment strictly in accordance with the manufacturer's instructions and with good practice in relation to infection control.

Wheelchair Equipment: All equipment provided by the NHS wheelchair service on long term loan remains the property of the NHS and is loaned to the Person for their use only. All long term loan wheelchairs must be returned to the NHS wheelchair service if the Person no longer requires the wheelchair. The Care Home will undertake to support the Person to keep the chair clean and in good working order, making sure that the NHS can access it for repair or review, undergoing training to operate the chair where this is necessary.

5.13 Assistive Technology and Telecare

Wherever possible and appropriate, the Care Home will maximise the use of technology to ensure monitoring and timely response. This will enable the Care Home Provider to improve the quality of care, prevent falls and avoidable admissions to hospital.

The Care Home Provider may, where they have risk assessed as safe and appropriate to do so, utilise assistive technology and telecare in the delivery of the Service, in accordance with the Person's Care and Support Plan.

The Care Home Provider will ensure that use of any assistive technology and telecare equipment is included in Staff training and that instruction for operating any equipment is part of the induction for new Staff.

5.14 Transport

The Care Home Provider will ensure:

a) A transport policy and procedure compliant with the Council's *Policy for Transport Arrangements* and the NHS Funded Transport Policy is in place and communicated to Staff and the Person effectively
b) Any transport provided is appropriately covered by the correct insurance
c) All transport required by the Person's Care and Support Plan will be arranged by the Care Home Provider in discussion with the Person and/or the Person's Representative
d) If the Care Home Provider is transporting more than one Resident in a multi-seater vehicle, the Care Home Provider must ensure there is an appropriate number of trained escort Staff, with no less than one member of Staff available in addition to the driver.
e) All Staff involved in transport should have specific training in issues relating to mobility and be aware of the needs and risks for each Person.

If the Person chooses to take part in activities in addition to those set out in their Care and Support Plan, the Service Provider may make an additional charge to cover the cost of the transport in accordance with the Individual Placement Agreement.

5.15 The Person's Legal, Financial and Personal Affairs

The Care Home Provider will ensure Care Home Residents:

a) Are encouraged to manage their own financial affairs wherever possible, in accordance with the Care and Support Plan.
b) Are supported to access assistance with their financial affairs if they so wish.
c) Are supported to obtain appropriate independent advice and assistance.
d) Are informed that Care Home Staff are unable to provide such help and assistance with their financial and personal affairs directly, unless it is of a very practical nature including day to day administration of the Person's Personal Expenses Allowance and other small sums of personal cash used for day to day purchases and to meet the cost of Other Services.

The Servicer Provider will:

a) Liaise with the appropriate appointed person about the Person's financial affairs
b) Liaise with the Commissioner or the Person's Representative if the Person loses the capacity to manage their financial arrangements while in residence at the Care Home.
c) Provide secure facilities for the Person to keep valuables near to them.
d) Support the Person to ensure their valuables are safely stored and secured.
e) Ensure the Person's personal cash is managed appropriately. The Care Home will ensure:
    - Personal cash is held securely in a locked cash box or equivalent and is kept separately for each individual Person.
    - A clear log of all transactions is made, including where money is given to the Person directly.
    - Receipts for all personal cash transactions made on the Person's behalf will be available, including Other Services provided by the home for which the Person is charged.
    - Monthly audits are undertaken to ensure the appropriate transfer and recording of personal cash transactions.

With the exception of small sums of personal cash the Care Home Provider will not handle the Person's money unless appropriate authority has been duly obtained by written consent from the Commissioner or the Person's Representative. Written consent from the Commissioner is required where the Commissioner has responsibility for the Person's finances. If a Person has capacity or a financial appointee, this will not apply.

The Care Home Provider and its Staff will not influence Care Home Residents with regards to their Last Will and Testament or any other legal document.

If the Person does not have the capacity to manage their finances, the Commissioner will assist the Person to make arrangements to check or secure the services of an Appointee or Deputy. Until such time that this process is concluded the Care Home will take steps to safeguard the Person from potential financial abuse.

5.16 Meeting Diverse Needs

The Care Home will ensure the Person's religious, cultural and spiritual needs are respected and supported. Staff will be properly informed about the implications of cultural and religious beliefs and will support the Person to take part and keep in touch with their faith communities.

Irrespective of gender, sexual orientation, race or religion the Care Home will ensure the health and social care needs of the Person are met. This will include arrangements for dietary

and personal care needs.

Where the Person has a disability, including sensory loss, the Care Home will ensure they are supported to maintain their dignity and independence and have equal access to information, choice and an environment that is suited to their needs.

5.17 Autonomy, Independence, Rights and Choice

The Care Home will:

a) Endeavour to ensure that the Person has control over decisions about their lives and the care and support they receive. The Person will be supported to access the resources to enable them to carry out their decisions and to meet the outcomes agreed in their Care and Support Plan. They will be fully supported to exercise choice and control over their lives.
b) Make necessary changes in order to accommodate the Person's individual needs and preferences
c) Ensure the Person is not moved to different accommodation without their consent unless there are exceptional circumstances, in which case the Care Home will consult with the Commissioner prior to any move, except in the event of an emergency.
d) Ensure the Person and/or the Person's representative has access to their personal files in accordance with the General Data Protection Regulation (2018) and that they have been informed in writing that these files may be reviewed as part of the inspection, regulation or quality assurance processes by the CQC or the Commissioner.
e) The Person is aided to exercise their right to vote, if they choose to do so. The Care Home Provider and their Staff will not, within the home, canvas or exercise undue influence for particular political parties.

The Care Home Provider shall empower the Person to take appropriate risks and shall manage the balance between promoting safety and positive risk taking. The Care Home Provider shall empower the Person to take appropriate risks, in accordance with their individual needs and their Care and Support Plan.

The Care Home will:

f) Ensure the Person has access to a Representative, friend, or advisor of their own choice to act as an advocate and they are supported to have access to the facility to pursue matters on their own behalf.
g) Ensure the Person is proactively supported to access independent advocacy services, where appropriate
h) Co-operate with the appointment of an advocate and assist the advocate in supporting the Person in accordance with advocacy principles and statutory guidance.
i) Provide information about where interpretation services can be accessed and the requirement for this should always be considered in the preparation of an assessment or review.

If the Person chooses to smoke, the Care Home will ensure appropriate arrangements are in place if the Person continues to smoke on admission to the Care Home. This includes where the Person needs mobility assistance to adhere to the Care Home's smoking policy. This may require an outside environment, which has been appropriately risk assessed for smoking.

With the Care Home Provider's agreement, the Person may choose to have a pet living with them at the Care Home. The Care Home Provider will ensure any pet owned either by the Care Home or the Person is well cared for and that they do not have a negative impact on the Care Home's environment or the safety and wellbeing of the Person and other Residents.

5.18 Maintaining the Person's Records

The Care Home Provider will ensure:

a) The Person's records are well maintained, organised and easily accessible. All required signatures are present and clear.
b) The Registered Manager or the Staff member delegated to by the Registered Manager reviews all records on a regular basis to assure quality and consistency of operational practice and recording and this review is recorded
c) The Person's records include background information that is proportionate and appropriate. It should include evidence of their involvement and their individual interests, preferences and wishes.
d) The Person's Care and Support Plan is developed in accordance with the requirements of this Service Specification.
e) Staff keep a comprehensive, written record of day to day issues arising for each Person. Staff must specifically record where the Person's needs have or have not been met in accordance with their Care and Support Plan. This should include the Person's feelings and emotions. Where an activity set out in the Care and Support Plan is not completed the reasons for this and associated actions must be clearly recorded.
f) Staff keep a regular written record of any significant events or issues including but not limited to outcomes achieved, accidents or incidents, illness, contacts with health professionals or other agencies, safeguarding concerns and issues arising relating to mental capacity or deprivation of liberty. These records should be comprehensive and person centred.
g) A central signature sheet is maintained to illustrate and identify the signature of each signatory.
h) All information in the Person's Care and Support Plan will be current and appropriate, any historical information should be archived unless where relevant to current Care and Support Planning.

6. Compliments, Concerns and Complaints

The Care Home Provider should demonstrate that they welcome complaints, concerns and compliments as an opportunity to continuously improve and develop the Care Home.

The Care Home Provider policy and procedure is expected to include information about how to make a complaint and timescales for responses. This should be communicated to the Person via the Care Home's welcome pack information, and display in the home.

7. Care Homes Building Safety

7.1 Fire Risk Assessment

The Care Home will ensure:

a) Fire risk assessments are in place and up to date.
b) Alarm tests are carried out on a weekly basis and recorded.
c) Evacuation procedures are in place and these are tested twice yearly and recorded.
d) The evacuation procedure for the building is reviewed by a Fire Officer
e) A Person Emergency Evacuation Plan is in place and accessible in the event of a fire.

7.2 General

The Care Home will ensure:

a) An environmental risk assessment is in place and is reviewed at least annually.
b) Regular and appropriate building checks are undertaken and appropriately recorded.
c) There is a clear method for reporting building hazards and repairs are actioned promptly.
d) All taps used by the Person are fitted with a thermostatic mixer or appropriately risk assessed and proactively managed
e) Temperatures in the Care Home are appropriate to the needs of the Residents, which will usually be between 18 to 21 degrees Celsius.
f) Outdoor areas are well lit and maintained
g) Environmental Health rating for catering facilities is on display

h) Suitable health and safety signs are displayed where appropriate.

8. Care Home Provider and Care Homes Staff

8.1 Nominated Individual

Where the Care Home Provider is a body other than a partnership the Care Home Provider will ensure the regulated activities of the Care Home are overseen by a Nominated Individual, who is responsible for supervising the management of the regulated activity provided in accordance with the Regulations.

8.2 Registered Manager / Provider

The Care Home Provider will ensure the Service is led by an effective and competent Registered Manager, who is able to motivate Staff and offers them a role model for best practice delivery of Care Home Services.

The Registered Manager will have achieved registration with CQC within six months of the commencement of employment as the Registered Manager in line with CQC requirements.

The Care Home Provider will notify the Commissioner of a change in the Registered Manager within 28 days of that change taking place.

8.3 Core Staffing

8.3.1 The Care Home Provider will ensure there is a designated leader on duty at all times. The lead member of staff will be aware of their roles and responsibilities and will be and accessible to both Staff and Residents at all times.

8.3.2 For Services registered as Care Homes with Nursing, the Care Home Provider will ensure there is a Registered Nurse on duty and on site at the Care Home at all times. This does not include any on call or sleep-in arrangement. All Nursing Staff must demonstrate the required skills; experience and operational practice and be registered with the NMC. The Care Home Provider will check NMC pin number and revalidation status and declaration of any other information relevant to professional registration such as sections of register or restrictions on practice.

The Care Home Provider will always ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced Staff to meet the Person's Eligible Health and Social Care Needs, provide the level of care set out in the Person's allocated Tier and to ensure the Care Home is staffed 24 hours a day, 365 days a year

8.3.3 The Care Home Provider will have a systematic approach to determine the number of Staff and range of skills required in order to meet the needs of all Residents. This will be sufficient to keep Residents safe at all times, taking into account:

a) The skills experience and competence of Staff
b) The fluctuating needs of Residents at different points during the day, week or year
c) The size, layout and registration of the Care Home. The approach taken by the Care Home Provider should reflect the current legislation and guidance.

The Care Home Provider will ensure the Care Home has a recorded Staff rota in place showing which Staff are on duty at all times during the day and night, the capacity in which they were working. The Care Home Provider will also hold a record of any Staff absences for the same period.

Where there is an emergency or other unforeseen event, the Care Home Provider will have procedures in place that ensure sufficient and suitable Staff are deployed to cover both the emergency and the routine work of the service.

The Care Home Provider will ensure regular Staff meetings take place. Staff meetings will be proportionate based on the size of the home, complexity of Residents need, any quality and performance issues and will generally be no less than monthly.

8.4 One to One Care Staffing

As part of the Person's Assessment and Care and Support Planning, the Commissioner, working together with the Care Home Provider, may identify the Person requires one to one care and support that is in excess of the care hours provided in Tiers 1 to 3.

This will usually be where the Person requires bespoke care due to the complexity of their needs or exacerbation of behaviour or risk of harm linked to disease, infection or condition. One to one care will usually be agreed on a short term basis with a view to reducing to the least restrictive level to achieve the Care and Support Plan outcomes.

All one to one care will be agreed between the Commissioner and the Care Home Provider before it is provided. The Commissioner will not be liable for the cost of one to one care that was not agreed in advance.

In exceptional situations where one to one care is required but there is insufficient time for advanced agreement, the Commissioner will cover the cost of the care if the Provider:

- Notifies the Commissioner in writing by the next working day.
- Can articulate to the Commissioner the reason for insufficient time to agree in advance and provides the evidence of the emergency or sudden significant change in the Person's condition.

One to one care will usually be provided from the Care Home provider's own staff. Where the Care Home is unable to meet an additional short term need for one to one care within its own workforce, additional agency Staff can be used. If agency Staff are used the Care Home Provider will source this care directly from the agency. In an emergency and where the Care Home Provider has been unable to source an agency member of Staff, the Care Home Provider may request the assistance of the Commissioner to identify the care availability, however any purchasing and management arrangement will be between the Care Home Provider and the agency identified.

Where one to one care and support is being provided for the Person to meet their Eligible Care Needs, the Care Home Provider will ensure there is a member of Staff assigned to the Person for the specified timescale agreed. The Care Home Provider must be able to evidence that any one to one support required is included on the Staff rota and that this is provided in addition to the normal Staffing ratio for the home. If the Person is admitted to hospital, any one to one hours will discontinue immediately and be reinstated when the Person returns to the Care Home. If the one to one care is explicitly required in the hospital the Care Home Provider must approve this with the Commissioner prior to deploying the Staff to the hospital.

One to one care will be monitored and reviewed by the Commissioner and may include unannounced assurance visits.

It is expected that one to one care is delivered by Staff who understand the care and support needs of individuals to ensure that one to one care is not a form of 'observed supervision', but an opportunity to:

a) Engage proactively and meaningfully in conversations and activities to ensure the Person is supported in a state of wellbeing
b) Understand how to detect changes in behaviour that, if recognised early, Staff can put techniques and actions in place to reduce the individual's anxiety and likelihood of further adverse escalation and harm.

The Commissioner will develop a process for the validation of one to one care and will include this in the requirements for contract monitoring. Care Home Providers may be required to evidence the delivery of one to one care on a case by case basis.

8.5 Staff Recruitment

The Care Home Provider will ensure the well-being and safety of the Person is protected by the Care Home Provider's policies and procedures on recruitment and selection of Staff.

The Care Home will proactively involve the Person in the recruitment of Staff wherever possible.

The Care Home Provider must ensure that these checks are made for all new Staff and volunteers joining their organisation **before** they start work in the Care Home, to include the following:

a) Fully completed written/typed application form
b) Verification of identity
c) Work permit (if appropriate)
d) Driving licence (if appropriate)
e) Certification of guidelines and training claimed
f) Confirmation of current registration status if holding a nursing, midwifery or health visitor qualification
g) NMC pin number and revalidation status
h) Visa checks
i) Other relevant professional registers
j) Two written references directly from the referee prior to the employment of Staff. Where practicable both should be from former employers, one must be from the potential employee's last permanent employer. The Care Homes Provider should make every attempt to verify the validity of the references and be able to provide evidence that they have done so. These will be dated and received prior to the commencement of employment
k) Any gaps in the employment record of potential Staff are diligently and sufficiently explored and that reasonable and satisfactory explanation is provided prior to the employment of staff
l) Records of fully completed recruitment and selection forms shall be retained and available for inspection

Any Staff or volunteers working with the Person must undergo checks made through the Disclosure and Barring Service (DBS) at the appropriate level. For Staff involved in the direct provision of Regulated Activities an enhanced DBS check is required. Where appropriate and subject to the Care Home Provider's receipt of adequate references, the Care Home Provider may employ a potential member of Staff who has a satisfactory Adult First Check.

In no circumstances should any individual member of Staff work unsupervised until a satisfactory DBS check has been obtained.

8.6 Staff Development and Training

Care Home Providers will ensure:

a) They have an induction programme that prepares Staff for their role. Including an organisational induction.
b) New Managers that haven't completed the Managers induction standards already will be required to do so.
c) Staff employed in the provision of care and support will meet or be working towards the Care Certificate standards.
d) New Staff are supported, skilled and assessed as competent to carry out their roles.

e) Training, learning and development needs of individual Staff members are carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role. Staff will be released to attend training as appropriate to their needs.

f) Ensure that all Staff providing care are fully trained in moving and handling techniques. Staff must receive appropriate moving and handling training and refresher courses and work to safe policies and practice regarding moving and handling. All training should be recorded in Staff files

g) Senior care staff should work alongside staff on the floor to embed training and ensure ongoing development of staff skills.

h) Nursing Staff have access to clinical supervision in accordance with NMC Guidance, and have maintained their clinical competence to demonstrate they can practise safely and effectively. All nursing Staff will have to demonstrate this through the NMC revalidation process and will need to demonstrate compliance with the Care Home.

i) The recommended and required Minimum learning and development in adult social care, as set out by CQC and the sector skills council as a minimum.

j) Basic life support training will be provided to all staff who have direct contact with Residents at least annually. Other mandatory training, as defined by the provider for their role. All Domestic Staff are trained to ensure the home is maintained in a clean and hygienic state

k) Any additional training identified as necessary to carry out regulated activities as part of their job duties and, in particular, to maintain necessary skills to meet the needs of the people they care for and support e.g. service specific training Mental Health, Dementia, Stroke ,LD, Diabetes, Dysphagia, End of Life, ventilation of the Person, verification of death, falls prevention.

l) Managers to hold, or achieve within 24 months, either a Level 5 Diploma in Leadership and Management for Adult Care OR an equivalent qualification, which may include but is not limited to:

- Level 4 NVQ in Health and Social Care
- Relevant nursing, physiotherapy or occupational therapy qualification and registration
- Relevant social work qualification and registration with the Health and Care Professions Council (HCPC)
- Degree/Master's degree related to social care.

m) Those Staff who do not already hold a Level 2 NVQ/ Diploma in Health and Social Care / Care / Healthcare or equivalent may wish to undertake the training and should be supported to achieve this

n) All learning and development and required training completed is monitored and appropriate action taken quickly when training requirements are not being met.

o) Refresher Training is provided to all Staff in line with recommendations from the Sector Skills Council as a minimum

p) Staff receive regular appraisal of their performance in their role from an appropriately skilled and experienced person, no less than annually

q) Staff receive regular supervision as required, in line with the requirements of the relevant professional regulator, that is at an appropriate frequency to their level of training and experience and not less than four times per annum

r) Staff are supported to obtain appropriate further qualifications that would enable them to continue to perform their role.

s) They do not act in a way that prevents, limits or would result in Staff not meeting requirements required by professional regulators for continuing professional development.

The Care Home will ensure Staff receives training appropriate to their position. For Staff involved in the direct provision of regulated care activities the Care Home Provider will follow the Skills for Care *Core and Mandatory Training* requirements and any subsequent core skills and mandatory training requirements issued by Skills for Care or their equivalent during the Contract Period. At contract commencement this as set out at

https://www.skillsforcare.org.uk/Documents/Learning-and-development/Ongoing-learning-and-development/Guide-to-developing-your-staff/Core-and-mandatory-training.pdf and include:

Topic	Refresher Frequency
Assisting and moving people	Annually
Basic life support	Annually and as required
First Aid	At least every three years
Communication	At least every three years
Dignity	At least every three years
Equality and Diversity	At least every three years
Fire Safety	Annually
Food hygiene	At least every three years
Health and safety awareness	At least every three years
Infection prevention and control	At least every three years
Medication management	Annually
Mental capacity and liberty safeguards	At least every three years
Moving and handing objects	Annually
Nutrition and hydration	At least every three years
Person centred care	At least every three years
Positive behaviour support and non-restrictive practice	Annually
Recording and reporting	At least every three years
Safeguarding adults	Annually
Safeguarding children	Annually
Specific conditions	At least every three years

Where there is a requirement to undertake refresher learning and development opportunities, Staff knowledge and competence should be assessed annually.

8.7 Volunteers

Subject to the status of the organisation, the Care Home Provider will identify and actively encourage opportunities to utilise Volunteers to enhance the quality of life experienced by the Person. The use of Volunteers will be to enhance the care and support provided by Staff and will not be used as an alternative.

The Care Home Provider will ensure:

a) The background, motivation and skills of Volunteers are assessed as competent to undertake the required tasks
b) Prior to taking up their post, Volunteers will have undergone all relevant Disclosure and Barring Care Home checks. The Care Home Provider will validate the Volunteer's eligibility to live in the UK and request and receive two satisfactory and appropriate references.
c) The tasks undertaken by Volunteers should be agreed with both the Staff and Care Home Residents and set out in writing.
d) Volunteers are given appropriate guidance, support and supervision to enable them to make an effective contribution to the Care Home Residents.

Where the Care Home Provider is unable to utilise their own Volunteers, due to the status of their organisation, they will proactively engage with outside organisations and services that are able to engage Volunteers to work with Care Home Residents. In this instance the Care Home Provider will be responsible for ensuring the requirements for Volunteers are met.

d) **Policies and Procedures**

The Care Home Provider will have in place and implement the following policies and procedures and ensure Staff are able to demonstrate an operational understanding of those relevant to their roles and responsibilities. Policies and procedures held by the provider will include but are not limited to:

a) Consent
b) Safeguarding adults and children
c) Mental capacity
d) Deprivation of Liberty Safeguards
e) Whistle blowing
f) Equality and diversity
g) Health and Safety
h) Moving and Handling
i) Accidents, Incidents and Emergencies – Reporting, Managing, Investigating and learning
j) Violence and aggression management
k) Falls Prevention, Management and Monitoring
l) Tissue Viability Prevention, Monitoring and Treatment
m) Risk Assessment and prevention
n) Record keeping, Confidentiality and sharing information, Data protection and subject access.
o) Medication policy and procedure
p) End of life
q) Verification of death policy
r) Infection prevention and control and contamination policy
s) Safe handling of Food Hygiene to incorporate Hazard Analysis and Critical Control Point (HACCP) guidance
t) Fluids and Nutrition
u) Fire Prevention policy
v) First Aid
w) Managing/Handling Residents finance
x) Use of Mobile Phones & Social Media policy
y) Compliments and Complaints Policy
z) Business Continuity - Procedures and Planning
aa) Employees Code of Conduct
bb) Recruitment and Induction
cc) Training, Supervision, Appraisal and Staff Development
dd) Personal safety at work
ee) Lone working
ff) Discipline and Grievance
gg) Financial Procedures
hh) Transport Policy
ii) Transmittable disease policy

9. Care Home Placements

9.1 For the avoidance of doubt, where the Service Specification refers to the Council, this will also apply to any social care Placements commissioned by Cornwall Foundation Partnership Trust (CFT) on the Council's behalf.

All Placements: The Commissioner will determine the relevant residential or nursing Tier as part of their assessment based on the Person's Eligible Needs. Tier 1 will be the default positon. Evidence about the hours of care required to meet the Person's assessed Eligible Needs will be required to determine the need for any Tier 2, Tier 3 or Tier 4 Placement.

Assessment by the Council: Where a Person has been assessed by the Council as having an Eligible Need the Council will work with the Person to determine an appropriate service. A

Mental Capacity Assessment may be required to determine a Best Interest Decision about a Care Home placement.

Assessment by NHS Kernow: Where a Person has a need for care 24 hours day, 7 days a week, they will be assessed by NHS Kernow or another appointed NHS organisation to determine eligibility for either Funded Nursing Care or Continuing Healthcare.

Funded Nursing Care is assessed under the Continuing Healthcare assessment process and determined where the Person had a positive Continuing Healthcare checklist but is assessed as not eligible after a full Continuing Healthcare Assessment using the Decision Support Tool. A Person living in a Care Home without Nursing may also be eligible for Continuing Healthcare subject to an assessment but will not be eligible for Funded Nursing Care.

If the Person is eligible for Funded Nursing Care or Continuing Healthcare, this will be paid to the Care Home Provider directly by NHS Kernow.

Joint Assessments: Where there is potential for agreement between the Council and NHS Kernow to jointly fund the Person's placement a joint assessment will be undertaken by a multi-agency team. In this instance the lead commissioning organisation will take responsibility for payment to the Care Home Provider.

Interim placements: Where a Person is assessed by the NHS or any other third party acting on behalf of the Commissioner as requiring a short term Care Home Placement with or without Nursing, they will be assessed by the NHS organisation and the funding will be agreed by the Commissioner.

The Care Home Provider will be aware of the assessment outcome and length of Placement and funding prior to accepting the Person.

9.2 Placement Brokerage

Vacancy Information: When a new vacancy becomes available, the Care Home Provider will update the web based bed vacancy tracker tool, as provided by the Council and/or NHS Kernow. This information will be used by the Council's Brokerage team and NHS professionals to identify suitable vacancies. At the Contract Commencement the bed vacancy tracker is https://carehomes.necsu.nhs.uk/

The Brokerage team may also contact providers directly to establish the suitability of current vacancies in the Care Home for individuals.

Where a new Care Home placement is required, the Worker will submit a request to the Council's Brokerage Team. This request will include the Worker's assessment of the appropriate Tier for the Person.

The Broker will use the bed vacancy tracker to identify suitable available vacancies. The Broker will use each provider's Rate Card to rank the available vacancies in order of value for money. The Broker will contact those Care Homes with vacancies to discuss the Person and to initially determine whether the Care Home can meet the Person's assessed eligible care needs. The Broker will then make a recommendation to the Worker about the best value for money option that can meet the Person's assessed eligible care needs.

The Worker will discuss the recommended option with the Person and the Person's Representative. Where there is more than one option at the same price, the Person and the Person's Representative will chose their preferred Care Home.

The chosen Care Home will be contacted by the Worker and asked to undertake their own assessment or to accept a trusted assessment for the Person. If the Care Home Provider agrees to accept the Person the Individual Placement Agreement will be awarded.

If the Care Home Provider identifies that they are unable to meet the Person's needs the Worker will discuss the next best value for money placement available with the Person and

the Person's Representative and the process is repeated until such time that the Placement is made.

Where the placement is being made in an urgent situation the Worker may discuss more than one option with the Person and the Person's Representative.

COUNCIL ONLY: The Person or the Person's Representative may chose a more expensive placement and a top-up will be applied in accordance with the Care Act 2014.

9.3 Pre-Placement Assessment by the Care Home

The Care Home Provider must be able to demonstrate that they have carried out their own comprehensive pre-placement assessment or have appropriately delegated this to another trusted professional or organisation.

Where a bed is available, the Care Home Provider will used their best endeavours to complete a pre-placement assessment within 24 hours of the date and time of the request being received and inform the referrer as soon as the assessment has been completed.

When considering the compatibility and suitability of the Care Home for the Person the Care Home Provider will consider:

a) The overall dependency levels of all Residents
b) Whether the Care Home has appropriate facilities, Staffing levels and Staff skills to meet the Person's needs

The Care Home Provider will confirm they can meet the Person's needs within the Tier recommended by the Worker.

When accepting any Placement in the Care Home, the Care Home will proactively check whether the Person requires a Needs Assessment to be completed by the Council. Where this is required, the Care Home will ensure this has been completed prior to the Care Home's agreement to accept the Placement. This is required to determine whether:

a) The Person has Eligible Needs for care and support
b) Funding for the Placement has been agreed by the Council through the agreed scheme of delegation
c) The Individual Placement Agreement is in place, to ensure payment can be made
d) The Person would be privately funding their own placement

New Referrals from Hospital: Where the Person is placed in the Care Home from hospital, either returning to the Care Home or as a new temporary or permanent Placement, the Care Home Provider will either:

a) Accept the Placement on the basis of the information provided by the health and social care staff in the hospital as a Trusted Assessment OR
b) Use their best endeavours to undertake the assessment within 24 hours of receiving the request for a Service.

Returning to the Care Home from Hospital: Where a Person has been admitted to hospital from the Care Home the Care Home Provider will recognise that the Care Home is the Person's own home and will work proactively with health and social care staff in the hospital to facilitate a timely return as soon as the Person is fit for discharge in accordance with the relevant NICE guidelines for transition between inpatient settings and Care Home settings.

9.4 Agreement of Care Home Placement Fees

Prior to the Placement Commencement the Commissioner will write to the Care Home Provider confirming the Placement Commencement date and the Fee agreed. The Fee will be

paid in accordance with the Care Home Provider's Rate Card, the Fee agreed for the relevant Tier.

9.5 Financial Assessment

COUNCIL ONLY: Once the Council has completed the Needs Assessment the Worker will make a referral to the Council's Financial Charging Assessment Team. This will initiate a financial assessment, to be undertaken by that team, to determine the level of charge the Person required to pay towards the cost of their care. The Council will notify the Person about the contribution they must make towards the cost of their care. The Person's Contribution will be included in the Fee paid to the Care Home Provider by the Council. The Council will collect the Person's Contribution directly.

From time to time the Financial Assessment Charging Team will review the financial contribution of a Care Home Resident, at which point the Council will notify the Person.

The Service Provider will contact the Council to instigate a new Financial Assessment if they believe there has been a change in the Person's circumstances.

9.6 Visiting the Home

The Commissioner will work with the Care Home to discuss and agree an appropriate person centred transition plan with clear timescales, in order to achieve a smooth and effective admission into the care home.

The Person and/or the Person's Representative must be offered the opportunity to visit the Care Home before a permanent placement is made. The requirement for a visit is waived where the placement is temporary, made in an emergency or to facilitate a hospital discharge.

9.7 Care Home Individual Placement Agreements and Individual Care Purchase Orders

Once the Placement has been agreed the care home will be notified they have been successful and confirm the Placement arrangements in writing.

Council ONLY: The Council will issue the Individual Placement Agreement, Schedule of Financial Arrangements and Care and Support Plan to the Care Home. The Individual Placement Agreement will set out the requirements from each party, which will include the Council, Care Home Provider and Care Home Resident and parties to the Individual Placement Agreement.

NHS ONLY: NHS Kernow will issue an Individual Care Purchase Order including the total Placement cost and the Person's Care and Support Plan. This will be shared with the Care Home and the Person who is fully funded health eligible.

9.8 Moving into the Care Home

Following the success of the agreed transition plan, the Council will work with the Person, the Person's Representative, and the Care Home to arrange and facilitate admission. This will include consideration about how the Person and their belongings will be transported to their new home, including their 'red bag' where relevant, and will include any special arrangements needed to ensure that the Person has the support they require for a successful move.

The Care Home Provider will consider any special pre-admission requirements, for example, Staff training, equipment or shadowing the current Carer to ensure that they are able to provide all elements of the person's care from the first day of admission.

9.9 Post Placement Review

Council ONLY: Following the commencement of the Person's placement, a review of the Person's Care and Support Plan will take place within the Initial Period of four weeks for the Council. This will involve the Person, the Council and the Care Home Provider representatives as appropriate.

The purpose of the Council's Review is to determine whether it is appropriate for the Person to remain in the Care Home after the Initial Period. If longer than 28 days is needed to determine this, the Council may, in agreement with the Person and Care Home Provider, extend the Initial Period on behalf of the Person. A new end date for the Initial Period will be agreed, and a further review will take place prior to this date. Any termination of the Placement will be made in accordance with this Contract. The Person's identified Tier may be reviewed at the post Placement review.

NHS ONLY: The purpose of the NHS Kernow Review is to determine whether it is appropriate for the Person to remain in the Care Home after the first 12 weeks, and consider if returning is an option if this remains the desired outcome. The Health Review will also include the Statutory CHC review if the person is a newly eligible CHC person. The Person's identified Tier may be reviewed at the post Placement review.

NHS Interim placements: The purpose of the NHS Kernow interim placement review is to determine whether it is appropriate for the Person to remain in the Care Home Placement after the first 4 to 6 weeks and will consider if returning to their own home is an option. Long term care options will be reviewed and this may require a Council or CHC assessment.

9.10 Ongoing Review

Council ONLY: After the Initial Period, the frequency of Council Reviews will be determined by the Care and Support Plan and will be within the Council's minimum requirements. If it is considered that the Eligible Needs of the Person have changed then any party to the Individual Placement Agreement may reasonably request a Review, which will consider what changes, if any, need to be made. Any changes to the Person's Eligible Needs that constitutes a change in the Placement Tier will result in a revised Individual Placement Agreement, which will be issued by the Council for signing by the parties. Where the Council and the Care Home Provider agree a change to the Person's Tier the new Individual Placement Agreement will reflect the Care Home Provider's Fee for the Tier, as set out in the Care Home Provider's Rate Card.

The Care Home Provider must inform the Council if they feel that there is a material change in the Person's needs, or in the way the Person would prefer to have their services provided, which may require the Council to review the Person's Eligible Care Needs and the Care and Support Plan.

The Council's Review will involve the Person and/or the Person's Representative and/or advocate, and the Care Home Provider or designated representative. Consideration will be given to ensure convenience and adequate notice for all participants wherever possible.

The Council will consider the extent to which the outcomes set out in the Care and Support Plan are being met and will identify future objectives.

The Person's Individual Placement Agreement will be amended as appropriate following the Council Review in accordance with this Agreement.

9.11 Exit from the Care Home

Any termination of the Placement will be made in accordance with the requirements of the Individual Placement Agreement.

The Care Home Provider will not discharge the Person from the Care Home except in accordance with this Contract and the Person's Individual Placement Agreement. The Council and Care Home Provider may mutually agree that the current placement in the Care Home is inappropriate and can therefore be terminated early. These reasons may include but are not limited to:

- The behaviour of the Person is unduly disruptive
- The behaviour of the Person is posing a threat to themselves or other residents in the Care Home
- The Care Home's environment causes a risk to the Person.

Where it is established by the Council or the Care Home Provider that the assessed needs of the Person are outside the category of registration held by the Care Home, the Council will make alternative arrangements for the Person as a matter of urgency. In such instances the Individual Placement Agreement will be terminated in accordance with the individual placement agreement.

9.12 Absence from the Care Home

The Care Home Provider will ensure that they are aware of the Person's whereabouts including whether the Person is in the Care Home, on a recreational outing or attending a pre-arranged appointment. A written procedure for dealing with missing Residents must be held by the Care Home and will include:

- Time for assumption the Person is missing
- Search of building(s) and grounds
- Telephoning likely places
- Informing Police
- Informing relatives where appropriate
- Informing the Commissioner

The Care Home must inform the Commissioner when a Resident is absent from the Care Home due to being unexpectedly admitted to hospital.

Where the Person should become absent from the Care Home because of admission to hospital, or for any other reason, the Care Home Provider will inform the Commissioner within 72 hours. The Care Home Provider will again notify the Commissioner after the absence has reached six weeks

The Care Home Provider will ensure that the accommodation occupied by the Person is kept available during a period of absence in accordance with the Individual Placement Agreement.

9.13 Death of the Person

Where the Person dies while living in the Care Home, the Individual Placement Agreement will end on the day of the Person's death. The Care Home Provider will notify the Commissioner of the Person's death.

The Care Home Provider will contact the Person's next of kin or where appropriate the Commissioner to make necessary arrangements, including a funeral, upon the death of a Person.

The Care Home Provider will not remove personal belongings without prior consultation with the Person's next of kin, who in normal circumstances should be given a reasonable opportunity to make arrangements for the removal of belongings within a timescale negotiated with the Care Home Provider. Where the Person's next of kin is unable to make

arrangements for the Person's belongings to be moved from their room, the Care Home Provider may relocate these items to a location elsewhere in the Care Home providing items are packed and stored in a respectful manner. This will usually be undertaken in exceptional circumstances, for example where the room is needed for an emergency Placement.

9.14 Care Home Closure or Failure

Where the Care Home Provider takes the decision to close the home or it is closed under enforcement action by the Regulating Body the Council and NHS Kernow will work with the Care Home Provider in accordance with the Council and NHS Kernow *Provider Failure Policy*.

Any associated termination will be made in accordance with the requirements of the Contract and the Individual Placement Agreement

9.15 Temporary Placements

For temporary placements, all requirements set out in the Agreement and Service Specification will apply in accordance with the period set out in the Individual Placement Agreement.

9.16 Short Breaks

For short breaks, all requirements set out in the Contract and Service Specification will apply in accordance with the period set out in the Individual Placement Agreement.

10. Quality Assurance

The Commissioner's Quality Assurance Team(s) will, in accordance with this Contract, undertake a quality assurance review using a risk based approach in respect of the Care Home Provider's performance of its obligations under the Contract. All Quality Assurance activity will be undertaken in accordance with the Quality Assurance Process for Commissioned Care and Support Services or any subsequent quality assurance process adopted by the Commissioner. Where appropriate and to avoid duplication, this information will be shared with NHS Kernow.

The Commissioner reserves the right to visit the Care Home and inspect any documents or areas of the Home required to ascertain that the Care Home Provider is able to meet the requirements of this Contract. These visits may be unannounced to ensure compliance and consistency. In undertaking these visits the Commissioner will have due regard for the sensitive nature of the Care Home Service being provided.

The Commissioner will use the data gathered from each Quality Assurance Review to:

a) Assure the Commissioner that the Care Home meets the Care Home Specification, Contract and good practice requirements
b) Assist the Care Home Provider in improving the delivery of the Services
c) Enable the Commissioner and the Care Home Provider to deliver their Co-Production objectives
d) Enable the Commissioner to assess the overall performance of the contractual agreement between the parties.

A Quality Assurance Review will include the quality requirements set out in Schedule 4C of this contract.

Following completion of a Quality Assurance Review, the Commissioner will produce a report of its findings and if required, in the reasonable opinion of the Commissioner, produce a Quality Assurance Improvement and Action Plan, which the Care Home Provider will be required to carry out in order for improvements to be made by the Care Home Provider to the delivery of the Services and in order to satisfy any obligations pursuant to the Contract. The Commissioner report will be produced in draft and the Care Home

provider shall have ten working days from receipt to query any inaccuracies or misinterpretations from the report.

The Commissioner may from time to time, but not more often than six months, undertake a (or procure the undertaking of) Resident satisfaction survey for the purpose of:

a) Assessing the level of satisfaction among People who use the Care Home
b) Monitoring the performance of the Care Home Provider in accordance with the Specification; and

The Care Home Provider acknowledges and agrees that Officers of the Commissioner may take evidence of risks and concerns identified during contract monitoring visits, including photographs and photocopies, and for this to be used to formulate a plan of action to ensure the Care Home Provider complies with the Service Specification..

The Commissioner Quality Assurance Process is subject to review and may change during the Term of the Contract. The Care Home Provider will be required to comply with any changes to the Quality Assurance process.

11. Contract, Performance and Outcomes Monitoring

11.1 Contract Monitoring

The Commissioner will adopt the principles of the Council's Contract Management Operating Procedure.

On an annual basis the Commissioner will assess Care Home Providers to determine their contract management classification of Strategic, Critical, Operational or Transactional (SCOT). This is determined by:

- **Risk:** Including quality and market risk factors
- **Spend:** Annual forecast spend
- **Scope:** Impact on multiple service areas
- **Duration:** Contract duration
- **Alignment:** Alignment of organisational aims and objectives
- **Opportunity:** Additional value

The Commissioner will notify the Care Home Provider of their classification prior to Contract Commencement. Where there are subsequent changes to the SCOT classification, the Commissioner will notify the Care Home Provider in advance of the new financial year on an annual basis. SCOT classification will usually remain the same for the Term of the Contract, save for where the 'risk' and 'spend' score significantly change year on year. This may occur where a provider significantly increases or decreases their business with the Commissioner and associated 'spend' and/or where issues relating to quality and performance affect the allocated 'risk' score.

All Care Home Providers will be required to comply with the Contract Management arrangements that relate to their SCOT classification. They will also:

- Contribute to the Care Home Provider Risk Register
- Contribute to and comply with any Continuous Improvement Plan.

11.2 Requirements for Strategic and Critical Classification

Where the Care Home Provider is classified as 'strategic' or 'critical', they will be required to:

- Attend an Annual Strategic Review meeting
- Submit an Annual Contract report
- Submit quarterly performance reports in accordance with the Performance Monitoring and Performance Indicators requirements of the Contract
- Attend quarterly Contract Review Meetings by exception, which may be increased to monthly by exception where the Commissioner identifies issues relating to the Care Home's quality, performance, or financial viability.

11.3 Operational and Transactional

Where the Care Home Provider is classified as 'operational' or 'transactional', they will be required to:

- Submit quarterly performance reports in accordance with the Performance Monitoring and Key Performance Indicators requirements of the Contract
- Attend an annual Contract Review Meeting, which may be increased to quarterly or monthly by exception where the Commissioner identify issues relating to the Care Home's quality, performance, or financial viability.

11.4 Other Contract Monitoring Requirements

At the request of the Commissioner the Care Home Provider will return the following additional information on an annual basis;

a) Business Continuity Plan
b) Financial accounts for the most recent completed financial year, audited if required by law
c) Information about the quality, repair and maintenence of the Care Home building
d) Insurance Schedules and Certificates
e) Results of the Care Home's personal outcomes survey. The Commissioner will use the results from the Care Home's survey to ascertain views on the quality and performance of the Care Home
f) A copy of the Care Home Provider's annual report including their service improvement plan.

The additional information will be held centrally by the Commissioners for the use of Commissioners.

11.5 One to One Validation

The Commissioner will have a process in place to validate the provision of any commissioned one to one hours and will monitor the delivery of one to ones as part of the contract monitoring requirements.

12. Performance Monitoring Indicators

12.1 Care Home Outcomes Monitoring

The Care Home will support the Commissioner in achieving the outcomes set out in the Adult Social Care Outcomes Framework and the Public Health Outcomes Framework, set out in this Service Specification.

During the first 12 months of the Term of the Contract the Commissioner will work with Care Home Providers to develop a Service Outcomes monitoring process. The achievement of Service Outcomes will then be monitored by the Care Home and the Council This may include but is not limited to:

- Monitoring of trends arising from safeguarding and quality assurance
- Admissions to hospital
- Feedback from Residents
- Care Home Provider's compliments and complaints log
- Staff knowledge and compliance with Service Specification requirements and Care Home policies and procedures
- Staff training and record(s)
- CQC inspection and reporting documents
- Other unspecified reports the Council and NHS Kernow may reasonably request from time to time.

12.2 Performance Indicators

The Care Home Provider is required to submit the following information for monitoring purposes only. This information will be considered in preparation for Contract Review Meetings and may affect the frequency of such meetings.

Performance Area	Year 1
Percentage of Care Home admissions from hospital assessed within 24 hours of referral	Monitor Only
Number of referrals accepted on the basis of a Trusted Assessment	Monitor Only
Non elective admissions to hospital	Monitor Only
Core Staff Ratios for nursing and care Staff	Monitor Only
Calculated Staff Turnover (%)	Monitor Only
Percentage of Agency Nursing Staff used during period	Monitor Only
Percentage of Agency Carer Staff used during period	Monitor Only
Percentage of total Residents vaccinated against flu	Monitor Only
Percentage of total employed Staff vaccinated against flu	Monitor Only

SCHEDULE 2B – DAY CARE SPECIFICATION

1.1 In addition to Care Home Services, the Care Home Provider may also offer a Day Care Service for a Person who is not Resident in the Care Home.

In the event that the Commissioner wish to purchase a Day Care Service for an individual and the Care Home Provider offers such a Service, the Provider shall deliver the Day Care Service in accordance the requirements of their Registration and this Contract, save for those conditions that directly relate to a Person's Residential status.

Day Care will consist of those activities included in the Service Specification for Care Home Services, as set out in Schedule 2A of this Contract as applicable to the Person's Care and Support Plan.

Where a Person attends the Care Home for a Day Care Service, the Person shall pay the Care Home directly for the cost of their meal and any subsequent refreshments plus any Other Costs incurred while using the Day Care Service.

1.2 Day Care Costs

The cost of Day Care will be determined by the Care Home Provider and will be costed on the basis of a hourly or sessional rate.

Requests for Day Care will be made via the current operations team and will be made based on the Best Value option available that can meet the Person's assessed Eligible Care Needs.

The Person is required to give 24 hours' notice from the start of the Day Care of any planned or unplanned absence from the Day Care Service directly to the Care Home Provider. If the notice is less than the given 24 hours, the Service Provider may charge the Commissioner for the Person's absence.

If the Person fails to attend the Day Care in an unplanned way for more than two consecutive sessions, the Care Home Provider shall notify the Commissioner.

1.3 Performance Information

Number of individual Person's attending Day Care who are commissioned by the Commissioner during the Period.

The Commissioner may request additional information from the Care Home Provider about Day Care during the Term of the Contract.

SCHEDULE 2C – RESPITE SPECIFICATION

1.1 Respite Services

In addition to Care Home Services, the Care Home Provider may also offer a Respite Service for a Person who is not Resident in the Care Home.

In the event that the Commissioner wishes to purchase a Respite Service for an individual and the Care Home Provider offers such a Service, the Provider shall deliver the Respite Service in accordance with the requirements of their Registration and Service Specification Schedule 2A of this Contract.

Respite will consist of those activities included in the Service Specification for Care Home Services, as set out in Schedule 2A of this Contract.