SCHEDULE 2 – SERVICE SPECIFICATION FOR HOME SUPPORT FOR CHILDREN AND YOUNG PEOPLE WITH DISABILITIES AND ADULTS [2024]

1. Introduction

1.1. This schedule sets out the Service Specification relating to the provision of home support for children and young people with disabilities and adults for Birmingham City Council and the NHS Clinical Commissioning Groups in Birmingham (the Commissioners). It describes the service aims, outcomes and standards the Commissioners expect from a service when a service is commissioned and one or both of the Commissioners pays towards that placement. This service specification should be read in conjunction with the Flexible Contracting Arrangement terms and conditions and the applicable Individual Service Agreement and Support Plan.

1.2. The provision of home support will be delivered in accordance with health and social care policy to all children and young people with disabilities and adults. This includes those with complex health needs, the presentation of behaviours that challenge services, mobility needs and physical disabilities; sensory impairment (including acquired brain injury); cognitive impairment; dementia, learning disabilities and/or autism; and mental health needs.

1.3 The Commissioners will expect the service to provide:

- care and support that enables the service user to do as much as possible for themselves
- a personalised and responsive service (with all staff delivering care being aware of service users' personal preferences & agreed outcomes)
- care and support that encourages autonomy and independence
- a range of stimulation to meet the individuals needs and wishes
- activities that are meaningful for service users
- equality of opportunity
- choice and the fulfilment of personal ambitions
- protection, dignity and respect
- relationship maintenance
- the meeting of religious, cultural and spiritual needs and wishes
- prevention of hospital admission and / or facilitation of safe discharge

1.4 This will be achieved by enabling service users to acquire, reacquire and maintain their own skills in line with their agreed outcomes so that they are able to achieve and maintain their potential in relation to physical, intellectual, emotional and social capacity. For the avoidance of doubt, the new 'principle of well-being' as defined within the Care Act 2014, recognises that everyone's needs are different and personal to them and assumes that the individual is best placed to judge their own wellbeing. The Commissioners believe this principle is relevant whatever a service user's age or complexity of need.

1.5 The provision of outcome based services will require changes to working practices and we will support Providers to develop new methods of providing this way of working.

2. Service Aims

2.1 This document sets out a specification relating to the provision of home support services by Providers who are registered with the regulatory body to support people who require personal care and support. This document describes the key features of the service being commissioned and should be read in conjunction with the Flexible Contracting Arrangement terms and conditions.

Service description

2.2.1 The tasks and support to be undertaken with and for service users are listed below. This list is neither exhaustive and may not be needed in all cases, and will depend on which tasks are identified as most likely to meet agreed service user outcomes. It is also important to emphasise that the list below is not prescriptive and should not preclude imaginative and alternative solutions which may better suit a service user.

2.2.2 The precise details of the tasks to be completed will need to be negotiated and agreed between the service user, relatives, carers, advocates and the Provider in order to achieve the outcomes stated in the service user's Support Plan. The details of these tasks must be clearly recorded in a personal service user plan and linked to the identified outcomes.

2.2.3 The main components of Home Support Service are:

Personal Care (children, young people and adults)

Practical Support with Household Management (adults)

Activities (children and young people)

2.2.4 Personal Care

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

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

Personal Care includes assistance with:

- Transfers from or to bed/chair/toilet;
- Assisting service users getting up and going to bed;
- Personal washing, bathing/showering and maintaining good personal hygiene toileting, shaving (use of cut throat razors prohibited), washing

and trimming of hair, hand and finger nail care, foot care, not toe nail care (which requires a state registered chiropodist);
- Eating and drinking;
- Assisting, prompting and or administration of medication;
- Assisting service users in dealing with correspondence and handling their money;
- Changing of catheter bags;
- Escorting to access community provision (e.g. shops, health appointments, leisure pursuits);
- Services to give carers a break (e.g. sitting services)
- Encouraging the continuation of hobbies and social activities.

2.2.5 Practical Support and Household Management (adults)

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

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

Cleaning and House Care

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

- Tidying the home;
- Making the beds and changing bed linen;
- Lighting fires.
- Disposing of household and personal rubbish;
- Assist with feeding and managing of pets subject to risk assessment;
- Assisting with the consequences of household emergencies.

Shopping and Meal Preparation

- Reasonable shopping (the amount of support to be agreed by the service user and/or defined in the support plan);
- Assisting service user to prepare food and drink, or preparing it on their behalf

Laundry Services

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

- Laundering clothes and household linen (including soiled linen), using either the service user's own equipment or a launderette, and ironing.

Other Household Management

- Collection of benefits, and prescriptions – must be administered in accordance with relevant appropriate procedures, and guidance of the respective authorities that regulate and/or oversee benefits and prescriptions.
- Payment of bills – in accordance with appropriate procedures;
- Maintain awareness of the safety of the home environment, alerting the appropriate person where risk is identified.

2.2.6 Activities (children and young people)

The Provider shall provide support to enable a service user to access activities and services available within their local community. This will include support to participate in hobbies and social activities.

The Provider will ensure that staff have access to up to date information regarding local community provision, to enable them to inform service users and their families of locally available, inclusive activities and facilities; including those provided through Extended Schools.

2.2 Service Flexibility
2.3.1 Agreed service provision details will need to be recorded in the personal service user plan. It should however be noted that Providers need to be flexible in the provision of Services, including tasks, hours and timing of visits. This is in accordance with the Core Principles under the Service Standards and the individual service user's choice.

2.3.2 This Service Specification allows for specific flexible care packages (usually for carer respite) where the provider and service user and/or Carer agree the hours to be used each week. The provider needs to ensure that the accumulative total hours for each 12 week period are not exceeded.

2.3.3 The Council will need to confirm whether the agreed tasks are in accordance with the agreed outcomes.

2.3.4 In the event that provision of care or support occasionally falls short of or exceeds the maximum agreed hours per week, the Provider and service user may agree to log any surplus or deficit. Providers will thus need to ensure that they have recording systems to manage these eventualities.

2.3.5 Whilst flexibility in service provision is paramount, Providers and their staff must only provide services which are legal and meet the service users stated outcomes.

3. Service Outcomes

3.1 This service specification demonstrates the commitment of the Commissioners to work in partnership with Providers to ensure a robust focus on service delivery that achieves optimum outcomes for the service user, in line with the four quality statements (domains) in the Adult Social Care Outcomes Framework and the five NHS Domains. The Commissioners believe these principles are relevant whatever a service user's age or complexity of need.

3.2 The Service outcomes are:

- enhancing quality of life for people with care and support needs including people with long-term conditions to enable service users to retain their independence, identity and sense of value
- ensuring that people have a positive experience of care and support including end of life care
- helping people to recover from episodes of ill-health or following injury
- treating and caring for people in safe environment and protecting them from avoidable harm
- delaying and reducing the need for care and support
- preventing people from dying prematurely
- develop and maintain close links with the community
- delivering care that is safe and that meets the required quality standards at all times

3.3 Each service user should have a care and support plan that is available to all staff delivering care, and that reflects individual outcomes to achieve the service outcomes. The domains and the care and support outcomes will be the standards with which the Commissioners will quality assure the services provided.

3.4 Eligible service users are likely to have a range of individual care and support needs relating to:

- a physical disability and/or restricted mobility
- frailty related to age
- dementia
- long term health conditions
- end of life
- a sensory impairment
- learning disabilities
- mental health needs
- acquired brain injury
- progressive neurological condition, such as motor neurone disease
- attention and conduct disorders
- the presentation of behaviours that can challenge services

This list is indicative and is not exhaustive.

3.5 Provider Support Plan
As a minimum therefore, the Provider Support Plan shall include and not be limited to:

- the desired outcomes identified by and with the service user and where appropriate their family carers
- the identified support needs of the service user and the associated tasks required to meet those needs
- how support should be delivered in accordance with the service user's wishes, needs, likes, dislikes, methods of communication, etc.
- how the service will support the service user to achieve their desired outcomes
- involvement of the service user's family, their circle of support and advocates as appropriate
- risk assessments and management/control measures
- links to health action planning
- all relevant manual handling, restraint agreements and behaviour management plans (as appropriate)
- medication support requirements (where service users are able to self-administer this should be clearly recorded and supported so that the they can maintain their independence for as long as possible)
- the timescale for the achievement of any time-bounded outcomes
- regular review arrangements
- details of the partial or full achievement of outcomes

3.6 Service Delivery
The provider(s) will deliver the service in line with national legislative and regulatory requirements, CQC Essential Standards, best practice and any Commissioner quality standards relevant to this provision. Birmingham City Council has a set of core standards for home support which are shown in Appendix A. A person centred, outcome based approach will underpin service delivery.

4. Service Standards
4.1 The Provider will:

4.1.1 Have a brochure / guide in appropriate formats as to the service provided, available for service users (or potential service users) of the Service, carers and professionals involved in setting up a Service.

4.1.2 Be able to demonstrate that the care and support required by every service user has been discussed with them and has been written down. The care and support plan should be completed by the service user and a suitably qualified and / or experienced member of staff prior to and upon admission. Where involvement of the service user is not possible, for example due to capacity issues, the provider will ensure the care and support plan has been completed with an appropriate advocate and or family carers if appropriate. The care and support plan should be added to according to changing needs

and risks but, in addition to that identified in Section 3.5, is to include (this list is indicative and is not exhaustive):

- emotional and psychological and mental capacity
- mobility, falls and frailty including manual handling
- health condition
- behaviour, cognition and communication
- tissue viability
- medication
- nutrition
- continence / incontinence
- washing and dressing and personal and oral hygiene
- cultural and religious

Where applicable additional assessments include:

- end of life care
- rehabilitation requirements following a period of ill health or hospital admission

4.1.3 Be able to demonstrate that the initial assessments have been reviewed at four weeks and then six monthly or more frequently if needs have changed. The assessments should be updated according to the changing needs of the service user. The provider will be able to demonstrate escalation processes are in place that supports findings from any assessment.

4.1.4 As far as possible, employ a workforce whose composition is reflective of the local population and ensure that staffing levels and skills mix are appropriate to meet all individual service user's needs.

4.1.5 Meet the service user's assessed mental and physical health, social, personal and cultural needs as detailed within their support/care plan. This may include supporting all aspects of personal care needs and to work in conjunction with multi-agency care programme approach that acknowledges and respects people's gender, sexual orientation, age, ability, race, religion, culture and lifestyle.

4.1.6 With reference to the Support Plan, produce a detailed plan in collaboration with the service user and family, of how they will meet assessed needs. This will include details of ongoing reviews. The support plan should aim to maximise service users' self-care abilities and independence by helping and encouraging people to do for themselves rather than having tasks done for them.

4.1.7 If outlined in the support plan, provide social, recreational and occupational activities which enhance the quality of life of service users and encourage participation and maintain autonomy and relationships.

4.1.8 Promote service delivery by trained and competent staff that encourages a preventative approach and maintains health and well-being such as encouraging a healthy diet, participation, and daily communication using appropriate methods.

4.1.9 If outlined in the support plan, support all service users to access primary care services to meet their health needs and ensure that service users are offered the opportunity to access preventative medications such as the annual flu vaccination.

4.1.10 Have a whistleblowing policy and procedure.

4.1.11 Ensure and evidence the service user's satisfaction with the service provided and demonstrate that good practice is celebrated and any issues are acted upon with an agreed outcome reached.

4.1.12 Recognise the intrinsic value of people, regardless of circumstances, by recognising their uniqueness and their personal needs and treating them with respect.

4.1.13 Protect the service user's legal rights, and that they have access to an advocate or other representatives if required. This includes applications for a deprivation of liberty (as defined within the Mental Capacity Act 2005 Code of Practice and the Deprivation of Liberty Safeguards Code of Practice).

4.1.14 Have a proactive approach to the changing needs of service users due to deterioration in physical or mental health, challenging or forensic behaviour. The Provider, where possible, should be flexible enough to meet such need without the service user having to lose their Service. If agreed by the Commissioner, this may involve increasing support to a service user in periods of temporary variations or fluctuations in their lifestyle or circumstances.

4.1.15 Have a range of policies and procedures that comply with all national and local legislation, guidance and best practice and these are frequently reviewed. The provider will make these available to staff through an on-going learning and development programme. The range of policies includes but is not limited to all aspects of support planning and risk assessment and should include a range of operational policies and procedures detailing how the provider will deliver the service, comply with all legal duties and reporting requirements together with providing quality assurance to the Commissioners.

5. Staffing Arrangements

5.1 Providers are required to ensure that all staff are trained and competent to ensure that service delivery remains effective and compliant with the level of service required. Providers should ensure that any training provider can meet the standards required by the Commissioners. The Provider should maintain a log of all training received and to be received and one that is available for the Commissioners to view upon request.

5.2 The Provider will ensure that all staff recruited from 1st April 2015 onwards has an induction together with on-going training and development in accordance with the Care Certificate (http://www.skillsforhealth.org.uk/images/projects/care_certificate/Care%20Certificate%20Standards.pdf). The Care Certificate is based on 15 Standards

that health and social care workers should adhere to in their daily working life. Designed with the non-regulated workforce in mind, the Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

5.3 For existing staff recruited prior to this date, the Provider will ensure that all of the principles of the Care Certificate are reflected in their ongoing training and development.

5.4 The Provider will ensure that resources for training and development are made available. This will be through a planned approach and staff have a learning and development plan in place from the point of induction. Staff should be released to attend training as appropriate to their identified training requirements.

5.5 The Provider must be able to demonstrate that staff have access to additional training to enable them to meet the needs of service users. This may include, for example, training in relation to dementia, Positive Behavioural Support, managing specific conditions or specific communication tools. Such training will be provided by accredited organisations and will be evidence based to reflect current specialist and social care and clinical guidance

5.6 The Provider must be able to demonstrate that staff are supported with continuous professional development with access to ongoing training and relevant qualifications available; and time allowed for take-up.

5.7 The Provider shall undertake a training needs analysis for all staff that is reviewed regularly and updated and formulated into staff personal development plans. This will feed into a monitored organisational training and development strategy and identifies when refresher training is required. The programme will enable a flexible response to individual learning needs.

5.8 The Provider will be able to demonstrate assessment of staff competency and performance management and documented evidence is available for inspection.

5.9 The Provider is required to register their establishment/organisation on the Skills for Care National Minimum Data Set (NMDS) and complete their worker records, so as to provide meaningful workforce data. This information should be reviewed and updated regularly, as a minimum, at least once every six months, in order to maintain the accuracy of the data available.

5.10 Details can be found on the Skills for Care Website, NMDS, www.nmds-sc-online.org.uk

6. Staffing Requirements

6.1 The Provider will ensure that the requirements of this Service Specification and any associated terms are met at all times and that continuity of service is maintained for service users.

6.2 The Provider will ensure that their service hours to staff hour ratio supports service continuity taking into account staff leave and sickness levels. Service continuity and staffing levels will support current services as well as potential new services.

6.3 The Provider will ensure that the service is headed by a CQC registered manager, who provides a role model of best practice to ensure that staff know what is expected of them and motivates them to deliver.

6.4 Additional guidance for a range of management skills can be found here: www.skillsforcare.org.uk/cqcguide and here: http://www.skillsforcare.org.uk/Leadership-management/Registered-managers/Your-induction-qualification-and-training.aspx

6.5 The Provider is responsible for safeguarding the health, safety and welfare of service users. They will take appropriate steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced staff appropriate to the needs of the service users and the volume of services being commissioned. In addition, the Provider will ensure that those left in charge of the service have the appropriate knowledge, skills and experience.

6.6 Staff will be supported through regular supervision, training, coaching and observation and competency checks. As part of the supervision process direct observations should be undertaken as well as an Annual Performance Appraisal (APR). The objectives identified in the staff APR should be reflective of the aims and objectives of the service. All supervision and APR should be underpinned by the Care Commitment.

6.7 Through ongoing supervision, service user assessments and feedback, the Provider will ensure that:

- staff competence is reviewed regularly
- staff are encouraged to develop their skills, including any specific training necessary to meet the needs of the service users
- all staff to demonstrate an understanding of and commitment to delivery of outcome focused care to each service user

6.8 The Provider will ensure that staff are able to manage risk, with confidence in their ability to strike a balance between protecting those in vulnerable situations and supporting service users to determine and achieve identified outcomes.

7. Record keeping

7.1 The Provider will ensure that all staff comply with all applicable statutory and legal obligations concerning information recorded in relation to service users.

7.2 The Provider will have policies and procedures for making, maintaining and securing service user records. The policies and procedures will detail the standards for recording client information, internal audit and quality monitoring, storage, archiving and destruction.

7.3 The Provider will maintain in the home and or office as appropriate adequate records including, but not limited to:

- assessments, care needs support plan, risk assessment etc.
- service user risk assessments on clinical condition e.g. mobility and falls and a summary of key risks such as times when this may increase
- documentation to show that identified risks have been reduced and how this is measured and monitored to reduce recurrence
- incident and accident book
- recording of financial transactions e.g. shopping tasks
- any complaints received and how they was addressed / actions taken
- If a service user has epilepsy a separate risk assessment and epilepsy protocol must be completed

Staffing

- records of pre-employment checks including DBS records
- personnel employed and basis of employment (permanent/agency)
- staff turnover
- timesheets
- staff training records
- staff supervision records

Complaints

- evidence of a complaints folder
- nature of the complaint
- name and address of the service user
- name and address of the complainant, where different
- date and time the complaint was received
- details of the process taken to investigate the complaint
- details of the outcome including the time and date of resolution of the complaint
- details of any action taken on the basis of the complaint to prevent future occurrence or improve service delivery
- names of employees and their supervisors involved in the action complained about, as appropriate, and any associated outcomes.
- any organisational learning arising in a timely manner and be made available to the Commissioners upon request
- complaint records including information concerning the nature of each complaint and action taken by the provider in each instance
- compliments, concerns, comments received by the provider

8. Medication

8.1 Policy For Administering Medication

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

8.1.2 Service users receiving Home Support Services may be responsible for administering their own medications in many circumstances and where possible should be encouraged to retain their independence by doing so.

8.1.3 The service user requires a Home Support Service for other tasks as well as medication and the service user has no one else to administer medication.

8.1.4 The service user cannot direct someone else to administer medication.

8.1.5 The Support Plan will state if medication is a requirement.

8.1.6 Compliance aids to self-administer medication have been explored.

8.1.7 The level of support must be documented and reviewed on an individual basis.

8.1.8 Service users in receipt of care from multiple agencies have a written agreement in place to identify which Provider holds the responsibility for assistance with medication.

8.1.9 Home Support worker may administer medication only after they have received training in line with the Care Quality Commission and NICE Guidance NG67 (or equivalent as may be issued by NICE from time to time) requirements and are following the procedure set out in this document.

8.2 Procedures and Requirements

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

8.2.2 Read the medication agreement for each individual service user which must be available in the service user’s home.

8.2.3 Follow strict hygiene rules in respect of thoroughly washing hands before and after assisting with medication.

8.2.4 Check all instruction on every visit thoroughly before administering medication.

8.2.5 Avoid handling medication directly and give to service users in an appropriate medical container.

8.2.6 Follow instructions and give service users water/drinks to be taken with medication where appropriate.

8.2.7 Record clearly any medication taken, refused, and spilt.

8.2.8 All care staff involved in assisting with medication must register and sign a sample signature for medication recording.

8.2.9 Only competent, fully trained and authorised care staff should administer medication and record, sign and date the Medication Administration Record (MAR chart) directly following administration of medication.

8.2.10 Medication refused should be reported immediately to the Care Manager and recorded on MAR chart.

8.2.11 Care staff must not leave medication out to take later.

8.2.12 The Medication agreement must state who has responsibility for ordering, collection and administration of Medication.

8.2.13 It should be clearly stated as to where the medication must be kept. If the medication has to be stored securely details must be made available to all staff responsible for assisting with medication.

8.2.14 Providers must ensure that safe return and disposal of medicines is recorded and incorporated within the policy.

8.2.15 In no circumstances should Providers remove or dispose of medication and records.

8.2.16 Providers must ensure that senior staff review all service users needing support with medication on a monthly basis to ensure staff are adhering to the policy, and that the MAR charts have been checked for accuracy (for action required where errors are identified, see Paragraph 8.5)

8.2.17 Changes and errors relating to medication must be reported to the Care Coordinator.

8.2.18 Refresher training must be updated to maintain competencies.

8.2.19 Providers must attend safeguarding meetings in relation to medication issues.

8.2.20 All medication records/MAR sheets must be clear and legible and

include all Medication to be given, timing of medication, type of medicine given, storage details, dates and signatures.

8.2.21 All ‘as required medication’ (PRN) must be clearly documented on a PRN protocol that gives clear guidance to staff when to administer.

8.2.22 Medication must not be given covertly (disguised in food) unless a Mental capacity assessment and best interests meeting has deemed it is in a person’s best interests for the provider to do so.

8.3 General Guidance For All Providers

8.3.1 All medicines must be in a monitored dosage system or in the container issued by the dispensing Pharmacist and labelled with:

- the service user’s name;
- name of the medication;
- dosage and strength of medication;
- frequency and time to be given; and
- date issued by the dispensing Pharmacist

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

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

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

8.3.5 The only exception to a monitored dosage system is when a short course of medication is prescribed, (10 days or less). Recording on MAR chart is required for the short course.

8.4 Hospital Discharge

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

8.5 Errors In Administration Of Medication

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

8.5.2 Contact the service user’s GP to seek advice;

8.5.3 Follow policy and procedures;

8.5.4 Inform the family/relative;

8.5.5 Inform ACAP or the Emergency Duty Team (EDT);

8.5.6 Complete a multi-agency safeguarding alert and forward to ACAP and also submit a standard notification to CQC; and

8.5.7 Relevant documentation to be completed and records of all activities must be available on request by the Council or health authority, e.g. Health Trust, Clinical Commissioning Groups etc.

8.6 Training Requirements For Staff Administering Medication

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

8.6.2 Training must include as a minimum:

8.6.3 Preparing dosages if liquid medication is required.

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

8.6.5 Non prescribed or alternative medicines.

8.6.6 Checking all instructions including the storage of medication/ medication documentation at each visit to ensure correct medication is given to the correct person whom they were prescribed for including checking dosage, timing and method.

8.6.7 Checking the expiry date of medication has not exceeded.

8.6.8 Checking medication has not already been given, for example by family members.

8.6.9 Observing changes or side effects from the service user and reporting.

8.6.10 Record all medication given.

8.6.11 Recording and reporting any refusals and medication errors immediately to managers.

8.6.12 Procedure for support with painkillers and other medicine not written into the care plan.

8.6.13 Understanding the Policy, including changes following hospital discharge and the individual's medication agreement and collection of medicines.

8.6.14 Risk Assessments for medication, reviews by Pharmacy/GP's

8.6.15 Care Quality Commission's policies for the administration of medication.

8.7 Employee skill level indicators and guidance for the administration of medicine and other treatment to Service Users (children's)

8.7.1 The Provider shall ensure adequately qualified and trained Employees administer medicine and other treatment to Service Users at all times. The Provider may use trainee Employees in the administration of medication and other treatments provided they are supervised at all times.

8.7.2 The following table shall be adhered to at all times:

PROCEDURE	**SKILL LEVEL**
ADMINISTRATION OF MEDICATION	
Central venous lines, including Hickman Lines	**1**
Continuous Ambulatory Peritoneal Dialysis	**2**
Epipens – adrenaline for allergy	**3**
Glucose monitoring	**3**
Buccal midazolam	**3**
Preventive (prophylactic) or crisis injection of insulin under the skin (sub-cutaneous)	**3**
Preventive (prophylactic) or crisis intravenous Factor 8 injection	**2**
Syringe drivers for iron chelation in Thalassaemia	**1**
Syringe drivers for pain relief	**1**
Treatment of unstable (brittle) diabetics	**1**
Human growth hormone injections	**3**

EARS

Insertion and removal of hearing aids	**4**
Olive oil to soften ear wax	**4**
Treatment drops	**3**

PROCEDURE	**SKILL LEVEL**

EYES

Drops or ointment for infection	**3**
Insertion and removal of false eyes	**3**
Saline drops for dry eyes	**4**

MOUTHS

Insertion and removal of dentures	**4**
Insertion and removal of retaining braces	**3**
Mouth care (tube feeding)	**4**

MISCELLANEOUS PERSONAL CARE

Acupuncture	**1**
Cutting of finger nails	**4**
Cutting of toe nails	
➢ Generally	**4**
➢ Where there are special health needs including diabetes	**1**

RESPIRATORY

Administration of oxygen	**3**
Physiotherapy for chest complaints, including cystic fibrosis	**3**
Tracheostomy care including suction	**1**

Treatment for asthma –

➢ Routine use of nebulisers	**3**
➢ Volumatics, inhalers and spacers for use in preventing attacks (prophylactically) or in a crisis	**3**
➢ Emergency treatment	**1**

PROCEDURE	**SKILL LEVEL**
SPECIALIST FEEDING	
Administration of bolus feeds through naso-gastric or gastrostomy tubes.	**3**
Administration of medication through naso-gastric or gastrostomy tubes.	**3**
Administration of pump feeds through naso-gastric or gastrostomy tubes.	**3**
Care of gastrostomy feeding equipment	**3**
Insertion of new gastrostomy buttons or tubes	**1**
Passing of naso-gastric tubes	**2**
T.O.F.S. feeding	**2**
GENITAL	
Enemas	**3**
	Use Employees of the same gender as the child or young person where possible.
Rectal diazepam	**3**
	Only with instructions specific to the child or young person involved
Rectal paraldehyde	**3**

	Only with instructions specific to the child or young person involved
Suppositories for pain relief	**3**
	Use Employees of the same gender as the child or young person where possible.

CONTINENCE

Catheters:

➢ Change of indwelling urethral catheter	**1**
➢ Insertion and removal of intermittent catheters	**2**
	Use Employees of the same gender as the child or young person where possible.
➢ Draining of catheter bags	**4**

Colostomy, ileostomy and urostomy care

➢ Changing and draining of bags, cleaning of skin and stoma, application of fresh template bag base	**4**
➢ Fitting of fresh template	**1**
Conveens	**4**

9. Key information & Significant Events Reporting

9.1 The Provider will take immediate and appropriate action and report the situation to the relevant bodies in the event of any of the following:

- abuse or neglect (Safeguarding via ACAP)
- inability of the Provider to perform any aspects of the service (Commissioner)
- hospital admission (ACAP)
- service closure (Commissioner and CQC)

- a temporary move (Commissioner)
- lost or missing service user (ACAP,CQC and Police)
- serious illness/injury/accident (ACAP and CQC)
- death (ACAP and CQC)

9.2 In the event of a major incident where the on-going delivery of care to service users may be interrupted, the Provider will take appropriate action as outlined in their Business Continuity Plan, notify the appropriate Commissioner *and follow up in writing to the relevant Contract Monitoring Team within 48 hours.* Major incidents may include:

- fire
- flood
- disruption to power, heat and lighting
- infection outbreak
- major staffing disruptions
- severe weather

9.3 In addition to the requirements of the Core Terms and Conditions in respect of Safeguarding, the Provider is required to note on their safeguarding log any organisational learning. The log should be kept up to date, and be made available to the Commissioner upon request.

10. Quality Assurance

10.1 Quality (http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf) is looking at a whole-system perspective, and reflects a concern for the outcomes achieved for service users and whole communities. The six areas or dimensions of quality assured are:

1. ***effectiveness:*** delivering care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need
2. ***efficient***: delivering care in a manner which maximises resource use and avoids waste
3. ***accessible:*** delivering care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need
4. ***acceptable/patient-centered:*** delivering care which takes into account the preferences and aspirations of individual service users and the cultures of their communities
5. ***equitable:*** delivering care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status
6. ***safe:*** delivering care which minimises risks and harm to service users”

10.2 Some examples of quality care issues are (this list is not exhaustive):

- falls
- medication errors
- concerns around nutrition and hydration
- poor personal care

- poor staff attitude

10.3 Birmingham City Council has devised an Assurance Statement that a provider is expected to complete six-monthly. The outcome of this process is then added to other information from:

- The Care Quality Commission (CQC)
- Performance data held by Birmingham City Council and the NHS
- Customer feedback from people using the services including feedback from Healthwatch Birmingham

10.4 The quality ratings help service users to understand the quality of service provided and look at the following factors:

- Giving people a good quality of life
- Helping people to be as independent as possible
- Involving people in the way care their care is provided
- Keeping people safe

10.5 All quality concerns and incidents will require the Provider to undertake an internal investigation which will be reviewed by the respective Commissioner as part of the quality assurance process. During this process a report on themes and trends will be expected from the Provider, on a quarterly basis, with related actions taken. The Provider will be expected to learn from the investigations undertaken as part of their own internal incident and investigation policies, providing feedback to the Commissioners within the themes and trends report.

10.6 The Commissioners reserve the right not to use the service to support service users if the outcome of the quality assurance process demonstrates a poor or inadequate rating or if any identified and actioned improvements cannot be sustained.

11. Safeguarding, Serious Incidents and Never Events

11.1 The Commissioners will expect the Provider to understand the difference between quality concerns and safeguarding, serious incidents and never events and to follow the appropriate actions for each including reporting routes.

11.2 Safeguarding concerns include (this list is indicative and is not exhaustive):

- physical abuse / hitting of patient by any party (including friends, family, visitors, staff)
- financial abuse or financial coercion of patient by any party
- sexual abuse/exploitation of patient by any party
- humiliation and degrading behaviour toward the patient by any party

These safeguards remain reportable through safeguarding routes as per safeguarding guidance on BSAB website https://www.bsab.org

12. Serious Incidents

12.1 Serious incidents are acts and / or omissions to act that result in:

- unexpected or avoidable death of one or more people
- unexpected or avoidable injury to one or more people that has resulted in serious harm
- unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent death or serious harm
- actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery
- an incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services
- major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation
- an incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services

13. Never Events

13.1 Never Events are serious, large preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Some examples of a Never Event include (but not exhaustive):

- bedrail entrapment
- fall from a poorly restricted window
- wrong route administration of medication (topical, oral, IV, IM etc.)
- insulin overdose
- nasogastric tube misplacement
- scalding of a service user

13.2 Any serious incidents and / or never event relating to healthcare that has caused or is determined to have caused harm are reportable. Serious incidents and never events should be reported to the responsible CCGs inbox as listed below.

CCG	Inbox/Contact
Birmingham CrossCity CCG	bhamcrosscity.seriousincidents@nhs.net - SI inbox bccccg.qualitychc@nhs.net - Quality CHC inbox
Birmingham South Central CCG	Bsccg.seriousincidents@nhs.net
Sandwell CCG	sandwell.incidents@nhs.net

Solihull CCG	solihullccg.seriousincidents@nhs.net

13.3 Where there are any doubts about reporting an incident then guidance should be sought from the relevant Commissioner on a case-by-case basis.

14. Personal Budget

14.1 Following an assessment this is the amount of money determined as sufficient to meet the eligible care and support needs a person has. These are care and support needs not already being met in other ways (e.g. by a carer).

14.2 Once the amount is agreed planning on how to spend it can begin. The City Council will help by using experience to agree a plan which meets a person's care and support needs.

14.3 How can a personal budget be used?
There are a number of ways a personal budget can be used to meet unmet eligible care needs.

14.3.1 There is the option to take a Personal Budget as a Direct Payment. This will give the best possible choice and control over how care and support is met. Support and guidance on direct payments will be provided by the Council and anyone can speak to a Social Worker about this option.

14.3.2 The Council will arrange the services needed to meet unmet eligible care needs.

14.3.3 Alternatively, it is possible that the arrangements could be a combination of the above 2 options.

15. Policy and Procedures

15.1 In addition to complying with all relevant legislation and the requirements of the Core Terms and Conditions**,** the Provider must ensure that there are policies and procedures in place. The Provider must ensure staff adhere to those operational policies and procedures. Policies and procedures will include but not be limited to the following, dependent upon the type of service, its CQC registration and the client group(s):

- Accepting gifts
- Access to records
- Activities
- Care and health planning including person centered plans
- Care Act 2014
- The Care Certificate
- Carrying out risk assessments
- Child protection
- Clinical governance
- Communications
- Use of own car for business purposes

- Compliments, concerns, complaints and comments
- Contingency planning and emergencies / BCP
- CQC Inspections – announced and unannounced
- Death on site
- Diabetes management
- Dignity and respect including privacy
- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Deprivation of Liberty Safeguards/mental Capacity Act (DoLS / MCA)
- End of life care
- Falls management
- Finance including funding sources, auditing
- Food hygiene
- Health and safety
- Human Rights Act
- Hydration and nutrition
- Incident and accident reporting including near misses
- Infection Control Hygiene Waste
- Information governance and data protection
- Managers Inspections
- Managing and Handling service users finances
- Medication Management including Medication Errors Records.
- Medications
- Mental Health Act
- Missing Persons
- New workers – induction and training record
- Ordering Medication / MARS Sheets.
- Personal care
- Personalisation CQC inspections and standards
- Quality assurance
- Recording visits from health professionals
- Recruitment including volunteers
- Safeguarding Vulnerable Adults
- Serious untoward incidents
- Service user engagement / consultation
- Specialist long term condition management
- Tissue viability
- Tobacco and alcohol use
- Use of / Calling emergency services
- Use of IT and other electronic media
- Use of social media
- Violence against staff including behaviour that challenges
- When taking service users on outings
- Whistle Blowing Policy

15.2 Human Resources

- Annual leave / flexi / toil
- Carers

- Consulting with staff
- Data protection and information governance
- DDA / Equality and diversity and inclusion
- Dress code
- Employment
- Equal Opportunities /Race relations
- Lone working
- Maternity /Paternity leave
- Out of hours emergencies
- Sickness / absence
- Staff conduct
- Staff supervision and appraisals and Continuous Professional Development (CPD)
- Staff Training Records
- Temporary agency or bank staff
- Training
- Use of mobile and company phones
- Working time directive

15.3 Equality and Diversity

- Equal Pay Act 1970
- Sex Discrimination Act 1975
- Race Relations Act 1976 (as amended 2000 and 2003)
- Disability Discrimination Act 1995 (as amended 2005)
- Human Rights Act 1998
- Employment Equality (Sexual Orientation) Regulations 2003
- Employment Equality (Religion or Belief) Regulations 2003
- Gender Recognition Act 2004
- Civil Partnerships Act 2004
- Employment Equality (Sex Discrimination) Regulations 2005
- Equality Act 2006
- Race and Religious Hatred Act 2006
- Employment Equality (Age) Regulations 2006
- Equality Act 2010

16. Behaviour that challenges

16.1 Behaviour that challenges must be considered in the context of the environment in which it occurs, the way the Service is organised and the needs of the service user.

16.2 The Provider must have a policy to positively engage and support service users who show behaviours that challenge. This policy will take account of all relevant legislation and guidance and good practice.

16.3 Continuing behaviours that challenge of a disruptive nature will require a consistent response by staff. The Provider must be aware of and have plans for known behaviour that challenges in the service user's Care Plan.

16.4 It is not acceptable to use any form of restraint (unless this has been agreed by a MDT and it is clearly documented on the Positive Behavioural Support plan the conditions when restraint can be used), verbal abuse or isolation as punishment for behaviour that challenges.

16.5 Any service user who has behaviours that challenge must have a positive behavioural support plan, which promotes understanding the context and meaning of behaviour to inform the development of supportive environments and skills that can enhance a service user's quality of life.

16.6 Any incident must be fully documented and include the antecedent, behaviour and consequence (ABC).

16.7 All incident forms must be audited by a suitably experienced manager to identify any triggers and patterns.

17. End of Life Care

17.1 The Provider will ensure that if a service user is on an end of life care pathway there are appropriate end of life care plans in place to which they have been consulted upon. This will include preferred place of death, Do Not Attempt Resuscitation (DNAR), nil by mouth medications and access to anticipatory medications.

17.2 The Provider will ensure that any end of life care plan includes:

- a record of who else to involve in the decision making (e.g. health professionals, next-of-kin, carer's)
- details of the service user's condition and treatment
- instructions for the service user's treatment in emergency situations
- confirmation if the service user's has any 'do not resuscitate' instructions in place
- a record of the service user's wishes with respect to place of care/death and decisions regarding their treatment
- confirmation that the patient's wishes have been shared with external organisations with the patient's consent (e.g. out of hours service, community nurses, secondary care consultants)
- preparation of carers and / or families end of life care expectations

17.3 The Provider will ensure that staff are trained in end of life care and that they use an appropriate framework such as the Gold Standard (http://www.goldstandardsframework.org.uk/) to deliver end of life care.

17.4 The Provider will engage community based services, as appropriate.

17.5 The Provider will refer to CHC team if eligible for CHC fast track funding.

17.6 For the avoidance of doubt this service specification uses the Medical Association and the Royal College of Nursing point of view in that a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) should only be issued after discussion with patients or their family. In England and Wales, Attempt Cardio-Pulmonary Resuscitation (CPR) is presumed in the event of a cardiac

arrest unless a DNACPR is in place. If a person has capacity as defined under the Mental Capacity Act 2005, that person may decline resuscitation. However any exploratory and or confirmation of choice discussion should not be in reference to the issue of consent to resuscitation but instead should be about eliciting an explanation.

17.7 A person may also specify their wishes and / or devolve their decision-making to a proxy using an advance directive, which is commonly referred to as a 'Living Will'.

18. End of Life Care UK Medical Profession Guidelines

18.1 The UK medical profession has quite wide guidelines for circumstances in which a DNACPR may be issued:

- if a patient's condition is such that resuscitation is unlikely to succeed
- if a mentally competent patient has consistently stated or recorded the fact that he or she does not want to be resuscitated
- if there is advanced notice or a living will which says the patient does not want to be resuscitated
- if successful resuscitation would not be in the patient's best interest because it would lead to a poor quality of life

In the UK, NHS Trusts must ensure:

- an agreed resuscitation policy that respects patients' rights is in place
- a non-executive director is identified to oversee implementation of policy
- the policy is readily available to patients, families and carers
- the policy is put under audit and regularly monitored

19. Business Continuity Management

19.1 Business Continuity Management (BCM) is about identifying those parts of an organisation that you can't afford to lose – such as information, premises, staff, clients – and planning how to maintain these, if an incident occurs. Any incident, large or small, whether it is natural, accidental or deliberate, can cause major disruption to an organisation.

19.2 BCM is an established part of the UK's preparations for managing risks faced by organisations, whether from internal system failures or external emergencies such as extreme weather, flooding, terrorism, or infectious diseases. The Civil Contingencies Act 2004 recognised its importance by requiring frontline responders to maintain internal BCM arrangements and local authorities to promote BCM to commercial and voluntary organisations.

19.3 A Business Continuity Plan is part of the management arrangements. A plan cannot be considered reliable until it has been tested and has demonstrated it can be effective. Exercising should involve validating the plan, rehearsing key staff and testing systems which are relied upon to deliver resilience. The service should demonstrate all staff have been directed and

taken up the opportunity to have the flu vaccination to ensure business continuity is maintained in the provision of a 24 hour 7 day service.

Appendix A

CORE SERVICE STANDARDS
FOR
HOME SUPPORT PROVIDERS
(Issue Date April 2024)

Service Standards

Introduction

In line with the emphasis of the Care Act (2014) the Commissioning Centre of Excellence has continued to strengthen its approach to reviewing the quality of services which the council commissions. Part of this approach has been to develop clear service standards to improve the quality of home support provision provided to service users, and to give clarity to providers as to the standards we are expecting and will be monitoring against. The Commissioners believe that these principles are relevant whatever a service user's age or complexity of need.

What is a standard?

A standard is a level of quality against which performance can be measured. It can be described as 'essential'- the absolute minimum to ensure safe and effective practice, or 'developmental' - designed to encourage and support a move to better practice.

The core service standards for Home support providers (which are detailed in this document) are determined as essential. It is important that standards do not become outdated or serve to stifle innovation and improve the delivery of care in the home support market. To prevent this, standards will need to be regularly reviewed and updated or added to at least annually, drawing upon the best evidence available.

The seven service standards

There are currently seven core service standards which have been developed to improve and/or maintain the quality of the service within the home support market. The seven core service standards are:

1. RECRUITMENT & SELECTION
2. INDUCTION
3. RISK ASSESSMENTS
4. CARE PLANS
5. CALL SCHEDULING

6. POSITIVE BEHAVIOUR MANAGEMENT
7. CITIZEN VOICE

Why are Service Standards important?

Currently, there remains considerable variation in the quality of services provided across the home support market. In order to improve the quality of these services, change is required. This needs to be underpinned and informed by a more cohesive approach to standardised monitoring for commissioning staff in order to undertake their duties. Additionally it will ensure provider compliance against the Flexible Contracting Arrangement.

These standards are applicable to home support services which are procured under the Flexible Contracting Arrangement. Service Standards establish a minimum level of performance to meet the compliance required by the market.

It is important that all home support providers own and incorporate them into their own organisation if we are to improve home support services to the service users of Birmingham.

SERVICE STANDARD – RECRUITMENT & SELECTION

Area	Standard	Checklist	Evidence
Recruitment and Selection	Recruitment Policy **(RS 1.01)**	The Provider will have a Recruitment Policy which will be readily available for inspection by an officer from Birmingham City Council (BCC). The Provider will be following their recruitment policy (which will be in line with the Service Standards outlined below).	
Recruitment Checklist	The Provider will have a recruitment checklist at the front of each Care Worker file listing all the elements of the recruitment process. **(RS 1.02)**	To ensure that the recruitment process has been completed the checklist will show dates/names when the various stages have been completed i.e. date contract signed, dates references sent and received and chased (if necessary), name of administrator completing the task and the date etc.	
Staff Recruitment – Application Form	Application forms will be fully completed e.g. full employment history including dates, explanations if candidate was not working.	There will be no gaps and no inconsistencies with dates, addresses, work history, education etc. in the completed application. (If the application has a question regarding educational history then this will be completed fully with attendance dates and name of educational establishment(s), courses etc., for at least the last five years).	
	Application forms must be signed and dated. **(RS 1.031)**	Date on application will be before care worker starts work.	

Staff Recruitment - References	The Provider will have a reference questionnaire/standard letter to request a reference. **(RS 1.032)**	A copy of each reference request sent out will be on the care worker file and will be addressed to the referees on the application form. (If the Provider uses a letter and a reference form than the referee's name will be on both).	
	There will be two references on each Care Worker file. **(RS 1.033)**	References will link in with the work history on the application form. All returned references will be checked by the Council. The Provider will make a note on the returned reference as to when the reference was checked and by whom. All references must be returned before care worker's start date. One reference must be from the current/ most recent employer. Referees will put their company stamp on the questionnaire, attach a compliment slip or reply on letter headed paper. If there is a telephone reference on file then the questions/responses will be fully recorded, dated and signed by Provider. If there is an e-mailed reference then all the correspondence will be printed off and kept in the file. E-	

		mail will not be from a 'hotmail' or 'gmail' account unless the company name is within the e-mail address. If there is a character reference on file there will also be an explanation as to why. One will be last or current employer. If no employment history, Provider will obtain professional reference.	
Staff Recruitment - DBS	The Provider will have an Enhanced DBS matrix showing all employee names, dates Enhanced DBS applied for and dates returned. **(RS 1.04)**	Enhanced DBS checks will be renewed every 3 years. Enhanced DBS' will be requested and returned before employment commences although some Providers may allow the Care Worker to commence employment under supervision i.e. double-up calls at long as they have obtained a first check against the safeguarding list and it is clear.	
	The Provider may have accepted a DBS from the previous employer **(RS 1.041)**	The Provider can accept a DBS from the previous employer providing that it is not more than 3 months old and in the same sector. The Provider will also need to evidence that a new DBS has been applied for immediately and that a risk assessment has been put in place until the new DBS has been received. The electronic DBS transfer can also be accepted and evidence provided.	
	The Provider will have a risk assessment policy/procedure in place for	If there are any convictions on returned Enhanced DBS' or declared on application forms and the candidate is	

	dealing with Positive DBS Returns. **(RS 1.042)**	employed then the Provider will have undertaken a risk assessment which will be on Care Worker file.	
Staff Recruitment – Right to Work Checks	The Provider will be able to evidence that appropriate right to work checks have been completed for staff from overseas. The Provider will be looking for documents issued by the Home Office, the Border and Immigration Agency or the UK Border Agency. The Provider must bear in mind that repeat checks may have to be carried out to ensure people continue to have the right to work. **(RS 1.05)**	Providers will check Passports, National Identity Cards, Registration Certificates or Document Certifying Permanent Resident are acceptable for EEA (European Economic Area) nationals who may work without restriction. For non-EEA nationals checks will be undertaken on Passports (biometric from 6 April 2015), Residence Cards, Accession Residence Cards (for Croatian nationals), Residence Permits (Biometric from 6 April 2015), Permanent Residence Cards (Biometric from 6 April 2015). Students – some are not allowed to work and some are allowed to take limited employment. Endorsement can be found in Passports or Biometric Residence permits* which states student is permitted to work and the number of hours of work allowed during term time. If this information is not set out in these documents the student does not have the right to work. Providers will also ask to see evidence of the course, the start/end date and a copy will be kept on the care worker's file	

		The Provider will take **colour** copies of the front cover of passports, copies of the pages providing the holder's personal details (nationality, photograph, date of birth, signature, expiry date) any pages containing UK Government endorsements' showing the person is allowed to work in the UK and carry out the work being offered. All other documents will be copied in full including both sides of any Biometric cards/permits. These documents to keep on Care Workers' files. Copies will be stamped or handwritten, dated and signed to indicate the Provider has seen the original documents. * *From 6 April 2022 Biometric Residence Permits are no longer accepted as evidence of right to work. Employers will have to complete an online Right To Work check via the Home Office.*	
Staff Recruitment – Other ID	The Provider has evidenced that other forms of identification has been collected for British Nationals. **(RS 1.06)**	The Provider can ask for current and valid Passports, current Driving Licence (photo-card or paper), Birth Certificates, Bank or Building Society statements, Credit card statements, P45 or P60, Council Tax statements, current utility bills (water, electricity, gas, (NOT ON-LINE)), letter from head teachers or college principles (this is not an exhaustive list). The Provider will take copies of the documents in full and there are copies on the Care Workers' files. Copies will be	

		stamped or handwritten, dated and signed to indicate the Provider has seen the original documents.	
Staff Recruitment – Interview	The Provider must formally invite candidates to an interview. **(RS 1.071)**	A copy of the letter inviting the candidate to an interview will be on the successful care worker's file and dated.	
	The Provider's recruitment policy will state that two members of staff undertake interviews and the position within the organisation of the interviewers. **(RS 1.072)**	Minimum of two staff members will be undertaking the interviews and each will use the interview question form. These will show the interviewers' names and the date.	
	The Provider will be using an interview question form pre-populated with set questions and space for the candidate's responses to be recorded. **(RS 1.073)**	The interview questions will be appropriate to the care industry and job requirement including the number of questions asked. Comments will also be recorded regarding the interpersonal skills of the candidate.	
	Candidate responses will be recorded. **(RS 1.074)**	The interviewers will each fully record the candidate's responses on each of the interview question forms and score each response.	

	Scoring matrix will be clear and transparent. **(RS 1.075)**	The scoring matrix will be clear detailing the minimum/maximum points that can be awarded for each answer. The scoring matrix will also be clear regarding the number of points required to be offered employment.	
	Service users are involved in the recruitment process. **(RS 1.076)**	This is good practice when possible. This could be a question set by a service user and asked by the interviewer, or evidence that the service user has come to the office to meet the candidate to personally ask a question.	
Staff Recruitment – Practical Tests	Literacy tests are used as part of recruitment process **(RS 1.08)**	*The Provider will use practical tests for literacy. Mathematical tests is good practice.* There will be copies on the care worker's file and evidence that the tests have been scored by the Provider.	
Staff Recruitment - Appointment	The Provider will formally give the successful candidate an offer of employment with a start date **(RS 1.09)**	A copy of the letter offering employment with a start date will be on the care worker's file.	
Contract of Employment	Contract of Employment on file. **(RS 1.10)**	There will be a copy of the Contract of Employment on the care worker's file that has been signed and dated by the care worker and the Provider.	

	Date of Contract of Employment. **(RS 1.11)**	The date on the Contract of Employment can be on the day the care worker started working or it could be after a probationary period i.e. 3 months. (Cross-check the employment start date)	
Staff Recruitment	Policies and Procedures as part of induction. **(RS 1.12)**	There will be a record in the care worker's file along with a signature and date to evidence that the care worker has read the Provider's policies and procedures. Some of the main policies are: Safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguardings, Medication, Equality and Diversity, Privacy and Dignity, Health & Safety, Manual Handling, Handling Service User's Monies, Complaints Policy, Whistleblowing Policy, Lone Working Policy, 'Out of Hours' Policy This is good practice. This record may also be kept with any training records.	
	Ongoing regular supervision **(RS 1.13)**	Staff will have a minimum of at least six supervision sessions a year of which at least four must be one-to-one supervisions.	
Staff Recruitment	Copies of Qualifications on file.	There will be copies of all relevant qualifications on the care worker's file as mentioned in the application form e.g. degrees, NVQ/QFC etc. The copies will be stamped or	

	(RS 1.14)	handwritten, dated and signed to indicate the Provider has seen the original certificates.	
Car Drivers	Current Insurance, MOT and Driving Licence	Provider will check that all car divers documentation is current, this will include insurance for business use, current MOT, full driving licence and copies will be retained on file	

SERVICE STANDARD - INDUCTION

Area	Standard	Checklist	Evidence
Induction Standards	The Provider will have an Induction Policy which states the aims of induction for the organisation and roles within the organisation. **(IS 2.01)**	The policy will be accessible and written in plain English so that it is understandable to all staff. There will be clear explanation of why the policy is required. The policy will provide information on who's who within the organisation and state their contact numbers The policy will cover all aspects necessary to help new staff members settle into their role. The policy will aid those responsible for the induction of new staff and existing members of staff who are changing roles.	
	The provider will be aware of the Care Certificate standards and will have incorporated them into their policy.	The Provider will have incorporated ALL the requirements of the Care Certificate into their induction policy.	

	IS (2.02)		
Duration of Induction	The induction policy will clearly state how long induction will last. **(IS 2.03)**	Best practice induction training will be broken down into manageable elements i.e. what the first day covers, what the second day covers etc. There will be written guidance for staff on organisational procedures – code of conduct etc. - this may be in the form of an employee handbook. Training for overarching policies and procedures will be phased over 14 working days.	
Induction Checklist	The Provider will have an induction checklist within the employee(s) file listing all the elements of the induction process. **(IS 2.04)**	To ensure best practice in service delivery from a new worker's first day, there will be a checklist to ensure all aspects of the induction process is completed. The checklist will show dates/names when the various stages have been completed i.e. date started, areas covered, and confirmation of understanding, date completed and space for signatures. Both the employee and trainer will sign the induction checklist as and when each element is completed.	
Staff Induction Plan	The provider will have an Induction plan, which incorporates all elements of the Care Certificate.	The induction programme will ensure that all staff have undertaken the mandatory training required for their role. The programme will cover all requirements aligned to the Care Certificate and Care Act 2014:-	

	(IS 2.05)	**Care Certificate** • Understanding your role • Your personal development • Duty of care • Equality and diversity • Working in a person centred way • Communication • Privacy and dignity • Fluids and nutrition • Awareness of Mental Health conditions, Dementia and Learning Disability • Safeguarding Adults • Safeguarding Children • Basic life support • Health and Safety • Handling information/ • Infection and Prevention Control **Addition Requirements by the Council** • Risk assessments • Manual handling (theory and practice) • Food hygiene/basic food preparation • First Aid • Medication (including completion of MAR charts) • Support Planning • Professional boundaries • Mental Capacity Act • Deprivation of Liberties	

		• Social Care Passport Evidence of training including workbooks and assessments will be in staff files along with final certificates. There must be evidence that the assessor(s) is competent in the standard they are assessing.	
	Direct Observations **(IS 2.051)**	There will be evidence of specific observations/assessment in order to comply with the Care Certificate. Indicating learning being put into practice within the required 12 week period.	
	Induction training will be specialised and condition specific **(IS 2.06)**	There will be condition specific specialised training for healthcare needs in addition to the mandatory elements of the Care Act	
	Where staff have completed the Common Standards Induction, they will need to complete the extra modules contained in the Care Certificate. **(IS 2.07)**	There will be evidence that the extra modules have been completed.	
	A check will be completed on 'new staff' that has completed the Care	The Provider will check competencies around the Care Certificate by, for example, direct observations and shadowing.	

	Certificate with a previous employer. **(IS 2.08)**		
Method of Induction Training	The provider will have tools and systems in place to deliver the induction programme. This will include tools for assessing the effectiveness of the employees learning. **(IS 2.09)**	The provider will demonstrate various methods of training e.g. in house, external trainer, DVD's etc. Are the training methods appropriate for the training area undertaken? If work books are used are the workbooks marked? If work books are not used and other methods are being followed then this must be sufficiently evidenced as per the Care Certificate requirements. Copies of the workbooks will be looked at to see if the learning methods are effective and fit for purpose. There will be evidence that the organisation has taken appropriate measures where an employee has not fully understood the training.	
	Employees will have a period of shadowing with an experienced member of staff.	Employees will have a period of shadowing with senior care staff prior to induction sign off. The induction policy will state what the shadowing period is - best practice is more than two shifts.	

	(IS 2.10)	Shadowing will cover a range of service needs e.g. moving and handling, dementia, autism etc. documentation will be completed for each shadowing event and there will be evidence on the type of task undertaken and competence of carer performing task will be recorded.	
	The provider will ensure that employees read and understand support plans and risk assessments before providing care to service users. **(IS 2.11)**	There will be a form for the employee to sign to evidence that they have read and understood the service users support plan and any associated risk. Evidence of signed forms will be in the service users file at the organisations head office.	
	The provider will have specific induction training for employees around completion and understanding of care documentation. **(IS 2.12)**	There will be guidance on how to understand and complete care documentation e.g. MAR charts, care notes, compiling and interpreting care plans, risk assessments and safe system of work etc.	
	The provider will undertake routine observations on all care providing employees. **(IS 2.13)**	There will be clear evidence that the provider is undertaking routine observations/spot checks. Observations will cover how the employee interacts with the service user, is the service delivered with dignity and in a timely manner. Observations will also include quality of daily recording, arrival times and leaving times and clear signatures.	

	The provider must undertake regular supervision meetings during the induction process **(IS 2.14)**	The induction policy will state the frequency of supervision meetings during the induction process. There will be evidence that supervisions have taken place in line with the induction policy.	
		-	
Ending the Induction Process	The provider has a process in place to sign off induction for new members of staff. **(IS 2.15)**	There will be a form/ certificate of successful completion demonstrating that the employee has successfully met all the outcomes in the Induction standards. This will include: • An induction plan which was agreed and has been followed through to completion. • The provider has directly assessed the individuals knowledge, skills and understanding and is satisfied that they meet or exceed the required standards. • The provider has reviewed any written evidence provided, witnessed or signed off by others and it satisfied with its authenticity and adequacy. • A continuing personal development plan has been agreed as part of the induction process and there is a written commitment to implement this. • Any role/condition specific induction requirements identified through recruitment and not covered by the Care Certificate have been addressed.	

SERVICE STANDARD – RISK ASSESSMENT

Area	Standard	Checklist	Evidence
Pre- package risk assessment	*Risk assessments will take account of the Health and Safety (HSE) 5 steps to risk assessment guidance.* *The risk assessment must clearly identify:-* ***Hazards** (potential to cause harm);* ***Risk** (the chance of likelihood of harm occurring) using either a low/medium/ high, or red amber/ green of a risk matrix* ***Control measures** (actions taken to reduce risk)*	Environment (inside home and outside) e.g. risk of trips, access, kitchen appliances, pets, cleanliness, furniture ,smoking Risk to lone worker(s) Care needs - do any of the care needs have associated risks e.g. partially sighted or providing personal needs in bed, personal needs (dressing, showering, changing incontinence pads etc.) Personality of individual or family members e.g. the service user may choose to make unwise choices, may be uncooperative, are families acting in the best interest of the service user. Capacity - is the service user able to make informed decisions/choices. Eating & drinking – is the service user able to eat and drink without support, do they require a special diet, is there a risk of choking, do they need their food need to be cut up, is there a need to monitor intake. Medication - can the service user self-medicate, do they need prompting, what are the consequences of not taking /missing meds, how are medications stored. Mobility – is the service user able to walk/stand unaided, do they need to use aids? Do aids need to be accessible?	

	Residual Risk : *needs to be adequately addressed if other than low* **(RA 3.01)**	Is there a history of falls? Does the service user require a raised bed or raised chair? Manual handling - do staff have to provide any support which involves manual handling? including lifting, transferring, aided standing and supporting mobility. Behaviours that challenge - is there a history of violence/aggression/verbal abuse to staff, self or others. Health needs - does the service user have health requirements e.g. use of catheters, tissue viability issues, mental health issues, physical disabilities, significant weight loss or gain, dementia, diabetes, stroke etc. Finance - does the service user manage their own money, do they need support when shopping. Do they need to give money to carer for shopping? Who has control of their monies/bank accounts, bank cards? Is the service user vulnerable to financial abuse? Access to the community - does the service user require additional support whilst out in the community. If the service user goes out independently is there a danger linked to crossing roads, getting lost, are they vulnerable to the actions of members of the public.	
Individual risk assessments	The risks identified on the pre start assessment. Risks will be identified as low, medium or high (green, amber, red or a scoring	Identification of risk - including how it fits into care plan probability and consequences of risk.	

	matrix). Where any risk has been identified as medium or high control measure need to be in place to reduce the associated risk. The risk control measure **will** be part of the care plan but must be identified that this is a measure to reduce risks. **(RA 3.02)**	Risk control measure(s) to reduce risk to include: - environmental factors, equipment needed, training needed, person centred care. Clear instruction for staff around what to do if risk(s) materialise. Residual Risk : needs to be adequately addressed if other than low Safe system of work - this includes identification of staff that need to be involved, communication /cooperation with the individual. This will clearly identify **safety critical** aspects of the activity. Agreement - the risk assessment needs to be agreed with the service user or their nominated representative. Annual Reviews - the risk assessment will always be updated/re-written when needs change or annually. The risk assessment will indicate when reviews of risk will be undertaken. This can vary depending on risk but it is good practice to review monthly. Reviews - there needs to be evidence that reviews have taken place in line with prescribed timescales. Accessible - risk assessments will be in a format which is easy to understand for staff and accessible to read within care planning. Where risks are low this will be stated, if certain areas of risk are not relevant this will be clearly stated.	

		Health needs - *these* will be in a format recognised by NHS teams especially in regard to medication, health monitoring, eating and drinking, tissue viability and health colleagues will, as necessary, be made part of assessment process. Staff risks - staff must be protected and suitable risk assessments for staff must be included e.g. lone working, pets, environment within the home and outside, manual handling, threat of violence, handling money. **Good practice - that all staff involved in the care of individuals sign to indicate that they have read and understood the plan.**	
	A separate Manual handling risk assessment needs to be in place where there are any risks identified. **(RA 3.03)**	Identification of risk, including how it fits into care plan probability and consequences of risk. Risk control measure to reduce risk to include: environmental factors, equipment needed, training requirements, person centred planning. Specific details of use of hoist will be included *including type of sling i.e. full or access, bathing or on site slings, sling use i.e. loop configurations to be used for task i.e. sitting of lying transfer. Sling maintenance and storage, and infection control procedures.* Specific instructions needed for use of other equipment will be included e.g. use of slides, walking aids.	

		There will be clear instructions for staff indicating what they need to do if risks materialise. Safe system of work - this includes staff that need to be involved, communication /cooperation with the individual. This will clearly identify **safety critical** aspects of the activity. Reviews will be monthly and updated e.g. when any falls occur, condition changes.	

SERVICE STANDARD – CARE PLANS

Area	Standard	Checklist	Evidence
Care Plans – consent	They will demonstrate that appropriate **consent** was gained. **(CP 4.01)**	Is the care plan signed and dated by all parties including the service user or family / carer? (If the individual is unable to sign is this documented?) Has the service user's capacity to consent to all aspects of the care plan been considered? EVIDENCE: • Evidence that a pre-assessment visit has taken place prior to the commencement of care. • Accurately reflects Social Worker/Community Nurse Support Plan	

		• Start date will be documented • Evidence of participation by the service user and/or their family – recorded in pre-assessment documentation. • Evidence of service user's preferences taken into account e.g. gender of C/W, language of C/W, times of calls etc. • Evidence of consent from the service user	
Care Plan format	The format will be **accessible**; easily understood by all who use it including the service user and the carer (and any agency staff). (The Care Act 2014, 4 (4). Care and Support Statutory Guidance, Issued under the Care Act 2014, 2.52) **(CP 4.02)**	Are the care plans clearly structured and do they include an index? Are they in an accessible format? e.g. large print / pictures / alternative language, information will be divided up into short sentences, paragraphs / bullets / numbers etc. Does the care plan include sections for: • Personal details • Personal history • Contact information for: next of kin, family, friends, GP and other professionals involved with the service user's care. • Medical conditions and allergies • Additional section(s) within the care plan as required detailing e.g.:	

		- Manual handling (where relevant) - Skin integrity (where relevant) - MCA / DoLS (where relevant) - Weight Loss - Nutrition - Provider details including 'out of hours' contact details **EVIDENCE:** Clearly structured including an index Accessibility has been considered and alternative formats have been implemented where relevant.	
Care plan details	Care plans will be **personalised** – it will be centred on the individual, their circumstances and needs and demonstrate their **desired outcomes** **(CP 4.03)** (The Care Act 2014, 1 (3) (a), (b), (e). Care and Support Statutory Guidance,	Are care plans written collaboratively with the service user / their carer(s)? Does the care plan reflect the package of care identified in the Social Work support plan? Is relevant information from the Social Worker's support plan including details of physical and mental health; well-being; (including attitudes towards any disability) and lifestyle (including how the day is spent); the contribution of informal carers included?	

	Issued under the Care Act 2014, 1.13, 1.14 (a), (b), (d), (e), 10.10). Important information Inc. medical conditions& emergency contacts etc. will be clearly indicated. **(CP 4.031)** There is guidance for care and support staff on the matters that need to be reported to the registered manager. Care call information including care to be provided will be clear and concise and this will be both accurate and current. They will be **<u>instructional</u>** e.g. contain information on how to carry out personal care / activities in a person centred way.	Is the care plan written in the first person or the person's perspective? (This may be using the service user's own words and phrases) Are the service user's personal details clearly recorded? (This could also include an individual's 'preferred name' and preferred communication method). Has a personal history (in addition to that provided by the Social Worker) been obtained - including likes and dislikes? Does the care plan reflect the service user's cultural and ethnic background as well as their gender and sexuality? Do outcomes relate directly to the individual's needs and goals? Are medical conditions including any allergies clearly documented? Are crisis and contingency arrangements included? Is there direction on procedures for reporting any concerns, responding to incidents and seeking guidance? Does the care plan clearly state the times and duration of care calls? Is the care plan explicit and instructional i.e. does the plan include relevant detail about how to appropriately perform care tasks? Is this clearly recorded in plain English and does it include enough information for someone else to implement the plan? (Would it make sense to a carer	

	(CP 4.032) There will be an emphasis on **delaying** the development of needs for care and support and the importance of **reducing needs** that already exist. They will demonstrate that an individual's **independence and choice** are being promoted; their **dignity and respect** are valued and their **right to privacy** is always observed. They will demonstrate that care and support is provided in the least intrusive way at all times with tasks being carried out *with the service user, not for them*, minimising intervention and supporting service users to take risks, as set out in their care plan. (The Care Act 2014, 2 (1) (a), (c). Care	unfamiliar with the individual?) If there is a lot of information is this broken down to make it easier to comprehend e.g. short sentences / bullet points or numbers / small blocks of text / appropriate font size. Is there evidence of an enablement process taking place? Does the care plan identify: • An individual's strengths and identify what they are able to do for themselves? • How the individual is being supported to stay healthy and safe and how it contributes to their wellbeing? • If service users have as much control as possible whilst being protected against unreasonable risks? This will reference the risk assessment. Is there information on methods of personalised interaction with the individual whilst care tasks are being carried out? e.g. preference for specific explanations / statements (possibly about the process) to inform and / or provide reassurance during care tasks. Are likes and dislikes in relation to the way that care tasks are carried out included? Is there evidence that the care plan offers an opportunity for the individual to make ongoing choices about their care on a daily basis?	

	and Support Statutory Guidance, Issued under the Care Act 2014, 1.5, 1.14 (c), (h)) **(CP 4.033)** **Safe working practices are promoted**: care plans will also include instructions on how to safely complete personal care / activities. **(CP 4.034)**	Are there clear instructions regarding safe systems of work – e.g. for double up calls – are there clear step-by-step instructions which demonstrate what is expected of each carer to safely complete each task? (these could be listed separately) – Are there instructions on the safe use of any assistive technology including the completion of a visual check to ensure the equipment is in good working order before commencing the care task? This will reference the risk assessment. Is the care plan up to date e.g. is all the information current and relevant? (There will be no evidence that information has been 'cut and paste' from previous care plans, there will be no contradictory information) **EVIDENCE:** Service user included – likes and dislikes included, personal details included, medical conditions and a thorough personal history recorded Desired outcomes recorded	

		Person centred including an emphasis on importance of clear communication with individual before and during tasks (including offering reassurance) and any other personalised response Written in plain English & from individuals perspective Essential information is provided (next of kin, family, friends, GP) Guidance to domiciliary staff is included:- Evidences choice Evidences enablement and any progress made Safe working practices are documented including directions on the inspection and use of any assistive technology and link directly to risk assessment and directions clearly broken down (chronological – time and motion fashion) Information is specific – including times of calls and duration of calls. Positive Behavioural Support.	
Care plans and medications	The support needed to prompt / assist or administer medication as required is detailed in the care plan.	Is the nature and extent of help required with medications administration detailed within the care plan? e.g. direct support with administering medication by selecting and preparing medication for immediate administration, applying creams, inserting drops etc. And if the individual	

	(CP 4.04)	is confused or likely to mistake their doses, is there detail about safe storage of medication? (Level of assistance must be recorded by the carer in the medication comments/recording sheet (held in the service user's home) on all occasions. The date, time of day and signature must be clearly written – a colour coding system could be used to identify medications taken at different times of the day) Is there a current list of prescriptions detailed within the care plan including: Name of medication • Dose • Time of administration • Frequency of administration • Method of assistance • Arrangement for the management of any medicines to be administered on an "as required" (PRN) basis e.g. pain relieving medication. Is there a PRN protocol in place advising when to give medications (time and / or circumstance)? The PRN protocol will include: - What the medication is for	

		- What side effects to look out for and what to do if they are present - The dose will be specific not a range especially for pain medication. - Any special information such as giving medication before / after food. For topical medicines; the site of administration will be recorded e.g. right shin. Are there instructions included within the care plan regarding the administering of medication (including safe system of work) e.g. asking the individual and checking the record sheet to confirm that they have not already had their medication. Instructions to only dispense from original containers or sealed monitored dosage systems dispensed and labelled by the pharmacist. Is there a safety checklist for the Home Care Worker to follow:- - Right Patient - Right Drug/Medicine - Right Time - Right Dose - Right Route	

		Does the care plan provide information on reporting refusals and medication errors including if the wrong medication is given? Are there instructions regarding changes to medications e.g. instructions not to give any medications not recorded within the care plan? (Any medications review will be documented and this section of the care plan will be amended). Are there MAR charts in place? **Evidence**: • Safe working practices documented • Information regarding medications recorded • PRN protocol in place (where relevant) • MAR charts completed and signed	
Personal Development of care staff	Provider delivering care to complex service users must demonstrate adequate training has been undertaken by care staff. **(CP 4.05)**	Any care staff delivering care to complex service users must have undertaken additional training to meet the particular specialist requirements of the service user and must be evidenced that the care worker is competent , examples could include working with service users who may have the following • Dementia • Diabetes • Catheter • Complex behaviour • Stoma bag	

		• Peg feed • Chronic Obstructive Pulmonary Disease	
Care plan review	As a minimum, formal review must take place once a year following an initial 28 day review. The review is completed by an appropriately qualified and experienced person. Review and revision of the care plan will take place at times or intervals dictated by changes in the need or circumstances of the service user e.g. hospital discharges and/or the request of their carer/representative. (The Care Act 2014, 27 (1), (b). Care and Support Statutory Guidance, Issued under the Care Act 2014, 13.10) **(CP 4.06)**	Is there a date for the next planned review recorded on the care plan? (This will be within 1 year). Is there a record that identifies outcomes of the review and any amendments to the service user's care plan? Is there evidence of progress made with the enablement process? Has the support plan been amended to reflect this? Is there a focus on what the individual is able to do for themselves? **EVIDENCE:** • Will include review frequency • Evidence of review • Next review date recorded There will be no evidence of information having been 'cut and paste' from elsewhere Care plans will be reviewed at all times if the service user's circumstances have changed	

Audit	MAR charts and Care notes will be audited on a monthly basis **(CP 4.07)**	Evidence of auditing ideally with a front sheet which has been signed and dated. Evidence that any issues have been followed up and addressed. Evidence of timeline of reporting lines and action taken.	
Care plan extras	Additional health plans will be linked to third parties e.g. GP or other Health Professional – care plans will correspond to these. **(CP 4.08)**	For individuals requiring additional monitoring, there will be detailed sections of the care plan covering: • Skin integrity • Fluid charts • Weight monitoring The above will refer to the risk assessment. Does the support plan include: • A health action plan for service user's with LD • Palliative (where relevant) • End of life plan • A Health Passport (where relevant) **Evidence:**	

		Any additional health plans are detailed in the care plan	
Care Notes / Daily records	Each entry in the daily records will include: **(CP 4.09)**	• All manual care notes must be written in black ink and clearly legible • Dated • Arrival and departure time (these will correspond to the care plan and time sheet, monitoring system) • Any reasons for variation of call times or duration of calls will be recorded • Mood of the individual on care worker's arrival and departure • Tasks undertaken during the call – these will relate back to the care plan. If tasks within the care plan are not carried out / completed as specified within the care plan, this will be recorded with the reason e.g. service user refusal • Identifiable name of carer completing the call • Signature of the carer	

		• If concerns have been highlighted in the previous recording, have these been followed through / acted upon?	
Care plan activities	Activity plans will be personalised to match the skills, abilities, and interests/preferences of each service user helping the service user reach his or her goals and where appropriate, to the service user's overall wellbeing. **(CP 4.10)**	Is there a range of activities identified (as appropriate)? e.g. leisure, therapeutic, skills based? Do they help with cognition, mobility, socialisation, skills development? Do they incorporate the service user's current interests, abilities to pursue these interests, adaptations needed to help the service user to pursue these interests, the service user's strengths, the goals to help the individual to reach his or her highest practicable level of well-being? Are any activities based in the community (if appropriate)? Do any activities encourage the service user to share the skills and abilities they already have? e.g. service users can be encouraged to share their skills such as knitting / crochet / gardening / music / cooking/ baking / explaining the rules of various sports. Do activities encourage the development of new hobbies, interests or skills? Are activities goals specific and measurable? Is there a method of recording an individual's engagement with the activity? Are their progress notes reflecting progress or lack of progress the service user makes towards activity based goals?	

		For service users with no discernible response, service provision is still expected and may include activities such as talking or reading to the service user about prior interests or tactile stimulation etc. N.B – all activity plans will reference the relevant risk assessment where needed.	
Care Plan – accessing the community	**(CP 4.11)**	For individuals being supported to access the community, the care plan will consider: • Level of support required e.g. 1:1, 2:1 • Use of assistive equipment (and any maintenance of this) e.g. walking frame, wheelchair etc. • Accessibility of transport (where required) • Accessibility of a building(s) • Support with accessing and managing money whilst in the community • Emergency procedures will be clearly stated e.g. epilepsy All of the above will reference the appropriate risk assessment	

SERVICE STANDARD – CALL SCHEDULING

Area	Standard	Checklist	Evidence

Call Scheduling	Provider will have a call scheduling system in place as appropriate in order to determine the number of calls being delivered, (this can either be electronic or manual) **(CS 5.01)** Call times for carer relating to delivery of care will be individualised to the service user / carer(s) at any one time /location All calls will be scheduled at least one week in advance **(CS 5.02)**	Calls will be scheduled on a rostering system, including • Name of service user • Location of call • Name of carer • Time and date(s) of call • Duration of call Call scheduling will not show any call cramming or multiple calls at any specific time on carers rota. Rostering system will be populated at least a week in advance, stating dates / time and name of care worker	
Travel Time	All care worker rotas will allow travel time between calls **(CS 5.03)**	Care workers rota will indicate adequate travel times between calls and locations	
Call Time Variations	Any changes to call times from the original S/W support Plan will be verified	Any variation to change in time of calls will have a local based agreement that indicate the following	

	and authorised by service user. **(CS 5.04)** Any single variations to the call time or duration will be recorded with a reason, including calls that are late, early or short calls. **(CS 5.05)**	• Reason for change • Previous time of call • New time of call • Signature of service user • Copy sent to the Council's ACAP team Evidence of auditing timesheets/electronic records against scheduled call times and recording reasons for variations If the calls include medication administration/prompting, then sufficient time between calls needs be considered in the variation of the timing of calls. There will be no variation of call times for call critical care tasks, such as insulin dependency relating to meal times. Reasons for variations will also be recorded by the care worker in the daily communication log.	
Out of Hours	Provider must have an operational out of hours /on call process in place during non-office hours **(CS 5.06)**	Provider must have a designated out of hours process, this will be evidenced as follows • Service user and staff aware of out of hours number and process • Out of Hours /On call documentation and follow up of any concerns • Out of hours policy	

Verifications of calls	Provider must have a system in place to audit delivery of calls at least on a monthly basis **(CS 5.06)** Providers will formally record on the service users file if they are unable to sign timesheets. **(CS 5.07)**	Audit of calls need to ensure that the provider has correlated the calls times on rotas against time sheets / call monitoring system and communication / care notes, Evidence • Audit process in place • Action undertaken for late / early calls, short or missed / dropped calls • Follow up on service users' concerns • Service user signature on communication / care notes (or UTS if the service user is unable to sign) • Communication logs / care notes have time and duration of call and signature of care worker • Manual time sheets have service user details, calls times (arrival /departure) and service user / family signature • Electronic monitoring system, if carer has not used or unable to use electronic call monitoring system reasoning for manual input. Where timesheets are used 'unable to sign' (UTS) recordings will correspond to the documentation on the service user's file indicating that.	

SERVICE STANDARD – POSITIVE BEHAVIORAL MANAGEMENT

Area	Standard	Checklist	Evidence

Care Plan and accessing the community	**All service users will have a positive behaviour support plan** **Why do they need one?** To help effectively respond to challenging behaviour a good Behaviour Support Plan is vital. A Behaviour Support Plan aims to reduce the likelihood of challenging behaviour happening and if used consistently is very successful in supporting the person to find other ways to communicate their needs. **(PBM 6.01)**	• Multi-disciplinary approach – advice will be sought from psychologist and or other clinicians • complete ABC charts • record four things about the challenging behaviour: “Appearance” – what the behaviour looks like “Rate” - how often it occurs “Severity” - how severe the behaviour is “Duration” - how long it lasts. Red, amber, green, blue (or other appropriate) status to be used. **Stages of behaviour** **Green = calm & relaxed** **Amber = anxious, aroused or distressed** **Red = incident** **Blue = calming down** Review and evaluate as necessary. Positive Behavioural Support is person centred Risk assessments completed and followed. **If physical restraint is used a protocol must be followed and staff trained and competent in restraint techniques which comply with NICE guidelines.** Violence and aggression: short-term management in mental health, health and community settings NICE guidelines [NG10] Published date: May 2015.	

	Incident recording and reporting **(PBM 6.02)**	• Incidents are recorded on incident sheets • Any incident is fully documented see PBS • Incidents are evaluated and lessons learnt • CQC, Care manager, safeguarding are notified as necessary. • Incident is also recorded on daily record sheets to ensure efficient cross referencing • If PRN medication is given this is noted on MARs and on incident sheet. Any changes in frequency of incidents are referred for specialist MDT support.	

SERVICE STANDARD – CITIZEN VOICE

Area	Standard	Checklist	Evidence

Citizen Voice	**Involvement and engagement of citizens** **(CV 7.01)**	All service users and their families/advocates are made aware, at the start of any service, that their comments and views (whether positive or negative) are welcomed. All service users and their families/advocates are given contact details of a manager they can talk to about their service and they are given information about how to make a complaint A record is kept of all complaints received, what action was taken in response, by whom, and what the outcome was. Every efforts is made to resolve the complaint to the satisfaction of the complainant, and as quickly as possible A record of all feedback received from service users, family members & advocates, and there is evidence of how this has been used to improve the quality of services Evidence of Citizen Involvement / Choice in: • Care planning • Management of risk • Positive Behavioural Support	

		• Communication strategies in partnership with speech and language therapist • Recruitment Person Centred Planning and accessible information utilised in the following areas • Service User Guide • Complaints • Advocacy • Care Plans • Reviews • Hospital Passports	