AGENDA ITEM No. 11

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 20 November 2024
Agenda Item	11
Title	Care Home Assurance Report 2024

Summary

This report provides an overview of the care home assurance tools (CHAT) submitted from care home assurance visits undertaken across East Renfrewshire in 2024. The report provides a thematic analysis, commenting on areas of good practice and opportunities for improvement, highlighting learning for care homes and East Renfrewshire Health and Social Care Partnership. The report additionally outlines the work of the Care Home Liaison Nurse team and wider HSCP Multidisciplinary teams in support of care homes.

Presented by	Julie Tomlinson, Chief Nurse

Action Required

The Integration Joint Board is asked to note and comment on the report.

Directions

☒ No Directions Required
☐ Directions to East Renfrewshire Council (ERC)
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)
☐ Directions to both ERC and NHSGGC

Implications

☐ Finance	☐ Risk
☐ Policy	☐ Legal
☐ Workforce	☐ Infrastructure
☐ Equalities	☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

20 November 2024

Report by Chief Officer

EAST RENFREWSHIRE CARE HOME ASSURANCE REPORT 2024

PURPOSE OF REPORT

1. The purpose of this report is to provide an overview of the care home assurance tools (CHAT) submitted from care home assurance visits undertaken across East Renfrewshire in 2024. The report provides a thematic analysis, commenting on areas of good practice and opportunities for improvement, highlighting learning for care homes and East Renfrewshire Health and Social Care Partnership (HSCP). The report additionally outlines the work of the Care Home Liaison Nurse team (CHLN) and wider HSCP Multidisciplinary teams in support of care homes.

RECOMMENDATION

2. The Integration Joint Board is asked to note and comment on the report.

BACKGROUND

3. Care home assurance visits commenced in East Renfrewshire in May 2020 in response to the impact of the pandemic. Annually across Greater Glasgow and Clyde (GGC) each HSCP, in partnership with local care homes, plans a schedule of assurance visits using a GGC wide validated tool. Local intelligence of emerging situations drives the focus for support and improvements and further visits as required.

4. The CHAT tool has defined areas of reporting covering Infection Prevention and Control (IPC), Resident Health and Care Needs and Workforce, Leadership and Culture. CHAT tools are discussed with the care home teams, good practice is celebrated and the learning shared locally at HSCP level.

5. A recent review of assurance visits and the template was undertaken involving extensive consultation with stakeholders including care homes, health, social work, commissioning, and Care Inspectorate. The sector recommended care home assurance visits continue, and that the CHAT tool was refined to reduce the number of questions and avoided duplication with existing structures.

6. The revised CHAT was tested in December 2023, with ongoing further refinements made based on stakeholder feedback. The updated approved tool was used throughout East Renfrewshire HSCP 2024 visits, (Appendix 1).

REPORT

East Renfrewshire HSCP Care Home Assurance Visits 2024

7. Over a 6 week period commencing 13th May 2024 representatives of East Renfrewshire Care Home Assurance Group visited all 13 care homes and completed the CHAT in partnership with Care Home managers and staff.

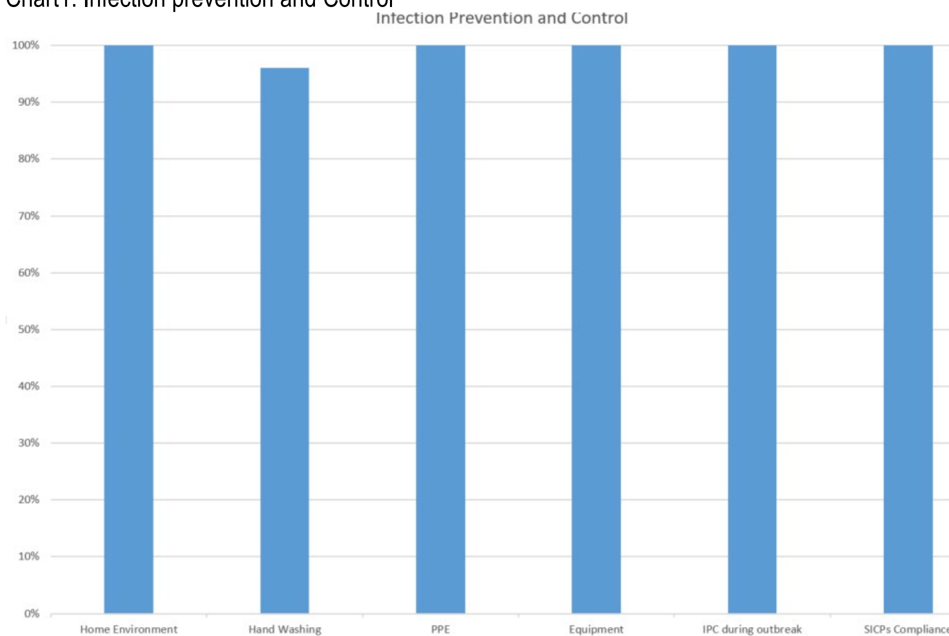
8. In preparation for the CHAT visits our Commissioning Team shared a copy of the new CHAT and each Care Home then completed a self-assessment prior to the HSCP visit. In preparation for visits the HSCP team complete a review of the self-assessment to identify areas for focus and discussion during the visit.

9. This report details the CHAT findings, commenting on areas of good practice and opportunities for improvement, and also highlighting any wider learning from the process.

Theme 1 - Infection Prevention and Control (IPC)

10. For the theme of IPC across East Renfrewshire Care Homes chart 1 shows the finding as follows:

Chart1: Infection prevention and Control



Entry to the home

11. Staff in homes were found to provide a warm and friendly welcome, directing visitors to hand hygiene facilities. CHAT outcomes demonstrate a plentiful provision of alcohol based hand rub (ABHR) at entryways.

Home environment

12. ER Homes were found to be well appointed, clean and tidy, with 92% fulfilling the requirements of this section.

13. Residents' bedrooms were found to be clean and well maintained with strong evidence across all homes of rooms being personalised with resident's choice of decor and personal belongings.

14. Where residents opt for less frequent cleaning, this was appropriately risk assessed.

Hand Hygiene

15. All homes were able to fulfill all requirements for hand hygiene, with supplies of ABHR and designated facilities throughout the home environment. Ongoing support and education for staff to support best practice in relation to hand hygiene continues.

16. 92% of homes achieved all aspects of hand hygiene practice. Care home visitors noted that staff were on occasion observed not bare below the elbow, either wearing wrist watches or bracelets.

17. CHAT templates captured some wall-mounted ABHR units that had not been replenished.

Personal Protective Equipment (PPE)

18. Care homes visited had an adequate, suitable and accessible stock of PPE for a range of activities. However due to over stocking during the pandemic PPE stock in a number of homes was noted to have expired.

Equipment

19. Homes continue to limit shared equipment as a means of preventing cross-infection.

20. Shared equipment was predominantly found to be clean and orderly. All homes were able to fulfill all requirements for the maintenance and management of equipment. Where CHAT outcomes noted equipment that was not visibly clean this was highlighted to managers and recommended inclusion to cleaning schedules.

21. A key recommendation was the need for signage and evidence of cleaning between uses.

DSR and Housekeeping (Monitoring the Care Environment)

22. CHAT visitors noted evidence of cleaning at the time of visit, and were confident in practices through conversations with knowledgeable housekeeping staff.

23. 100% of homes were able to demonstrate robust practices with regards to maintenance and monitoring of the care environment.

Laundry

24. All homes were able to fulfill the requirements for laundry processes, with advice posters, suitable wash temperatures and segregated areas for clean and dirty linen.

IPC Training

25. Consistent with previous visits, all homes have robust internal process for ongoing IPC training and completion rates were noted to be high.

Monitoring compliance with Standard Infection Control Precautions (SICPS)

26. All homes had processes for monitoring compliance with SICPS, such as observation of hand hygiene and donning doffing of PPE as well as more formal systems such as audit.

27. Staff receive feedback on their performance, either at the time of observation, as part of regular one-to-one, or at team meetings.

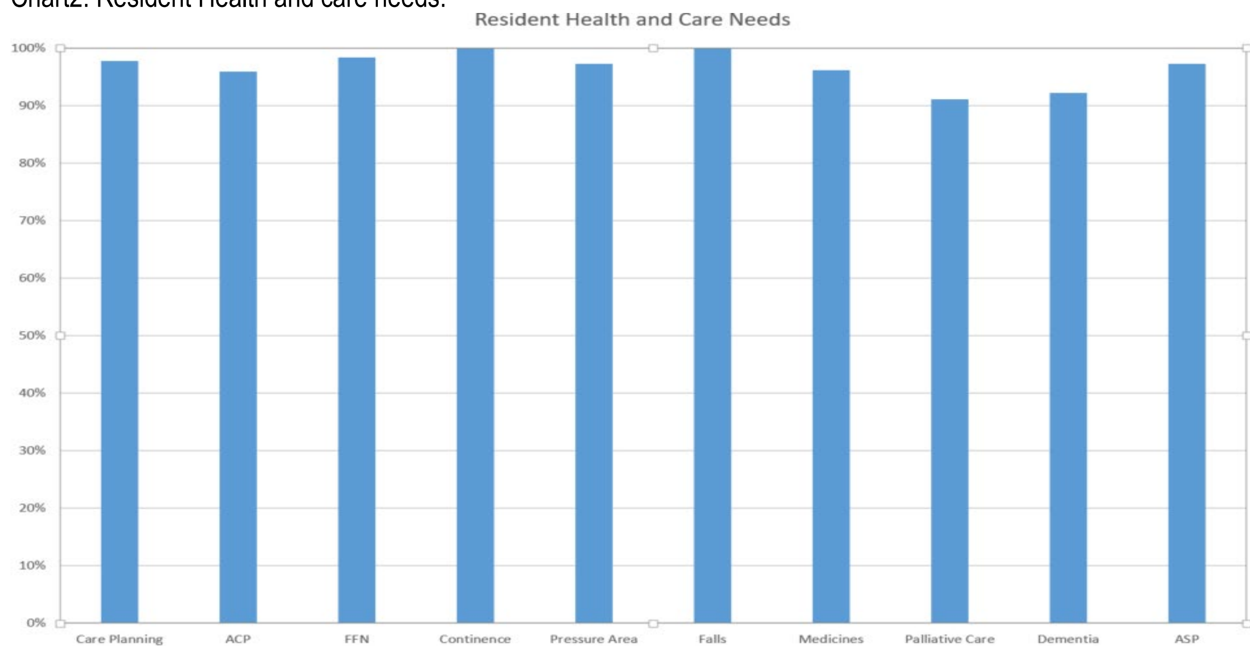
IPC during an Outbreak

28. All homes visited could detail their plans for management of an outbreak. Care home teams voiced actions such as isolation of residents, escalation of concerns to leadership teams and public health, this was consistent across all 13 homes.

Theme 2 – Resident Health and Care Needs

29. The following chart highlights the findings of care assurance visits within the theme of resident's health and care needs.

Chart2: Resident Health and care needs:



30. Chart 2 illustrates that care planning and practices relating to residents health and care need were found to be of a high standard across East Renfrewshire Care homes with multiple examples of good practice. The excellent practice observed during the CHAT was recognised and feedback given at the time of visits.

Care Planning

31. Care planning remains an area of strength with 92% of homes fulfilling all requirements, and demonstrating care planning which supports resident's health and care needs.

32. There were good examples of care plans that detailed the resident's life stories, who and what is important to them, and discussed what upsets the resident and what makes them feel better. In some homes Care plans considered not only issues of care needs and risk assessment, but took a strength-based approach, documenting resident's abilities and considering how these could be supported.

33. Consistent with previous CHAT visits, recommendations for improvement centred on the record keeping of handwritten notes, their legibility and attribution. CHAT visitors recommended that providers encouraged staff to reference the NMC and SSSC guidance in support of improvements.

Anticipatory Care Planning/Future Care Planning

34. Anticipatory Care Planning or Future Care Planning (FCP) practices remain an area of strength. End-of-life wishes are considered within care plans, and DNACPRs are in place for those residents who may need them.

35. Homes are able to recognise and report changes using RESTORE2 and RESTORE mini to help standardise the recognition and communication of deterioration. All homes noted good working relationship and further support available such as GP services, community nursing teams, pharmacy and specialist palliative care services.

Food Fluid and Nutrition

36. 100% of care homes provided access to meals and stalks throughout the day and overnight.

37. 100% made reference to the use of nutritional screening, predominantly using MUST (Malnutrition Universal Screening Tool).

38. CHAT visitors noted the display of information on texture modified diet and fluids and likes and dislikes are recorded in personal plans.

Pressure Area Care

39. 92% of homes fulfilled the necessary aspects of pressure area care.

40. Good practice was noted in the use of pressure ulcer safety cross to track the inheritance or development of pressure ulcers; and the use of the Red Day Review tool, to audit pressure area care.

41. CHAT tools highlighted that homes are accessing support from community nursing teams and podiatry, and that homes have access to a range of redistributing equipment as required.

42. Staff training on pressure ulcer management was highlighted as an area for ongoing improvement.

Adult Support and Protection

43. ASP themes included wound care, medication errors, altercations and verbal exchange between residents, and unwitnessed falls which resulted in injury. Additionally complaints regarding staff behaviour towards residents are highlighted as an issue.

Medicines Management

44. 100% of care homes were able to evidence staff training in medicines administration and regular medication audits taking place.

45. Relationships with local pharmacies to carry out polypharmacy review was highlighted as an area for improvement.

Falls

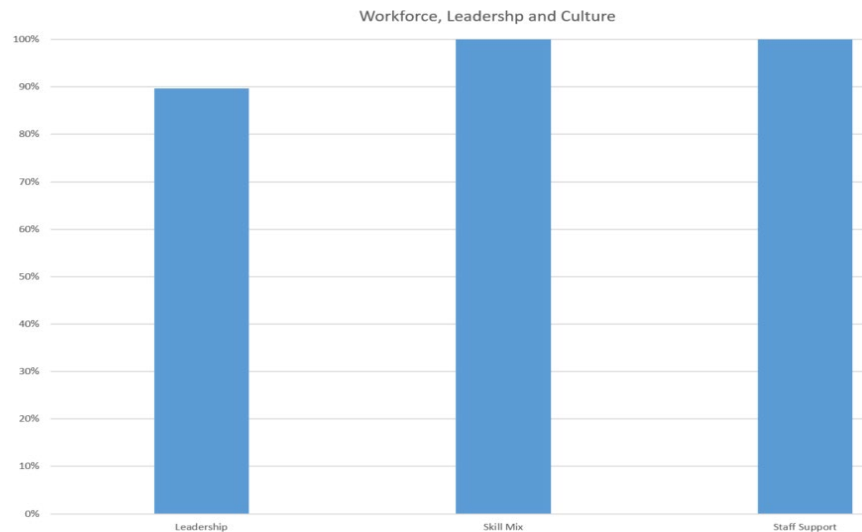
46. 100% of homes carried out falls risk assessment for residents, however some services reported that this was not care their residents required. Falls awareness and prevention training is carried out via a range of e-learning platforms and the good links with the HSCP Rehab team for assessments and treatment plans was noted.

47. Homes also made reference to use of the Falls Pathway through the NHS GGC Flow Navigation Centre.

Theme 3 - Workforce, Leadership and Culture

48. Effective leadership and support from the care home's wider organisation can be directly correlated with how supported staff feel, the overall culture of the home and the care residents receive. This section provides a narrative of key themes in workforce, leadership, and culture for East Renfrewshire care homes.

Chart 3: workforce leadership and culture



Workforce

49. Staff reported feeling content within their roles. Care home visitors noted that staff were open to conversation and keen to discuss future events.

50. Homes continue to celebrate the achievements of staff mentioning the completion of SVQ qualifications.

51. The staffing picture remains mixed, with some homes fully staffed, with limited requirements for agency. Conversely, homes noted that their shortage of registered nursing staff was negatively impacting on the quality and consistency of care provided.

Leadership

52. Care home visitors complemented the work of care home managers. New managers have positively impacted their homes, and long standing managers are providing consistency of leadership. The importance of good relationships with staff was highlighted as a factor, making staff teams feel valued and positively shifting culture.

Culture

53. In reviewing culture, care home visitors spoke with residents and families who reported being happy within their home and with their care.

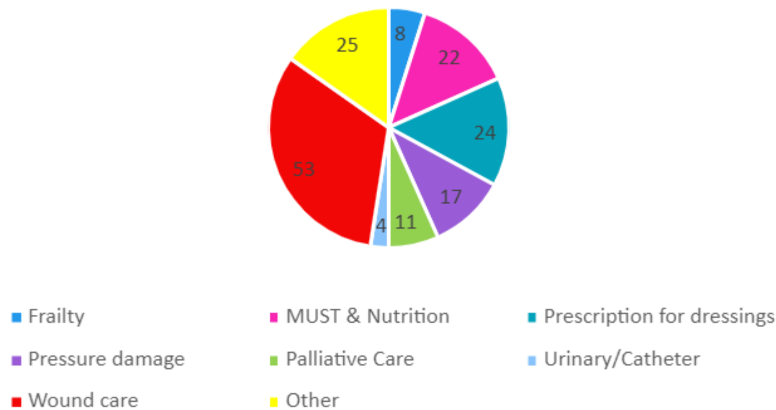
Wider care home support available.

54. **Care Home Liaison Nursing Service (CHLN):** works in partnership with Care Home nursing staff to deliver high quality, enhanced nursing support to people living in an older adult Care Home. This includes those being discharged from acute care or transferring from the community to a Care Home setting. The CHLN service are an integral part of the wider multidisciplinary (MDT) Care Home Support Team providing an expert nursing

resource. The CHLN provide enhanced support 7 day service and focus work around admission avoidance and Palliative end of life care (PEOLC). The team support and advise Care home Staff in the provision of nursing care for residents and their families by providing the following:

- Supporting discharge and transitions between Care Homes and hospital.
- Supporting prevention of unnecessary hospital admissions.
- Supporting Care Home staff to use an anticipatory person centred approach to identifying residents preferred place of care.
- Provision of expert nursing resource to ensure all resident needs are met and taking action to raise concerns and support investigations when required.
- Support Care Home staff in the provision of palliative and end of life care for residents ensuring timely identification of deterioration and symptom management.
- Developing a system of partnership working with Care Home Nurses through provision of clinical advice and providing clinical interventions as and when required e.g. peg tube management or suprapubic catheter insertion.
- Supporting Care Home nurses to make referrals to wider services when required
- Undertaking a range of clinical assessments when this is necessary to support specialist advice e.g. continence, falls, tissue viability, palliative and end of life care, physical and cognitive functions.
- Assisting Care Home staff with care planning to meet the individual needs of residents in line with NMC nursing standards and in the implementation of evidence based practice to meet agreed local and national standards.
- Supporting Care Home nurses to proactively improve their ability to effectively manage long term conditions and maintain functional ability of residents and avoid unnecessary hospital admissions, where possible.
- Sign posting to other specialist services as required and education and training events within the locale.
- Supporting attainment of additional clinical competencies and areas of practice development as require.
- Facilitating local clinical skills training and development of competencies for Care Home Nurses to meet individual resident needs if out with their scope of practice.
- Sharing guidance and acting as expert resource when required
- Utilising patient information systems to identify all patients admitted to hospital from care homes.
- Sharing information gained with multidisciplinary team when required.
- Participate in the evaluation and audit of the CHLN Service to continually improve service delivery.
- Prescribing V150/V300 specifically wound care products/palliative end of life care medications.

55. **CHLN Referral process:** A referral process was set up in April 2024 in order to create a more formal route for care homes to contact the CHLN team for support, this also provided a data source recording the categories of referral reasons which in turn has informed the development of training, education and support the CHLN team provide. In the period care homes have made 129 referrals to CHLN service the graph below shows referral reasons:



56. **Vaccination Team:** The Vaccination Service operate a home visit model, with vaccines administered to all eligible residents in all East Renfrewshire care homes, additionally care home staff are offered flu and covid vaccine as part of the process. The service also provides support in regards to consent and AWIs within care homes working in collaboration with Commissioning and Care Home Liaison nursing services. Vaccine campaigns during 23/24 period have seen care home uptake and delivery of vaccine at 98%.

57. **Older Peoples Mental Health Care Home Liaison service:** The team are a dedicated secondary care mental health team, who are responsive to the mental health needs of individuals living in East Renfrewshire care homes. The service is triggered from GP referrals to ensure reversible causes of distress have been considered and ruled out as contributors to distress in the first instance. The team's role supports individuals living in care homes with moderate to severe mental health needs, and/or stress and distress in dementia. The service is also involved in the diagnostic process of new diagnosis of dementia.

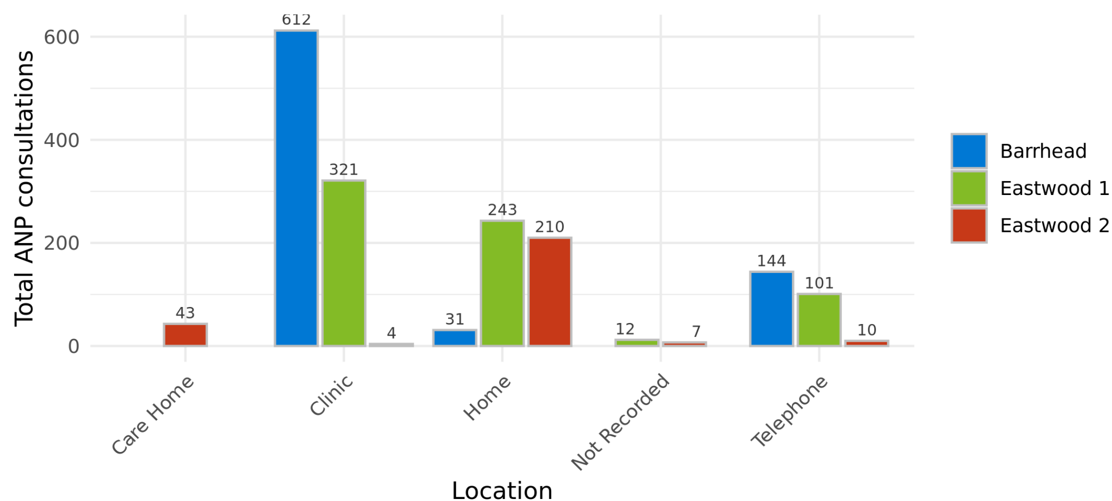
58. The team offers a proactive and preventative model of care, providing regular stress and distress in dementia training, which also encompasses the impact of frailty and delirium on the individual living with dementia. This upstream working has enabled the team, to build collaborative relationships with the care home teams, resulting in reduced stress and distress for individuals and staff, a reduction of antipsychotic medication which was already prescribed, and a reduction in psychiatric admission from care homes and the prevention of placement breakdown.

59. Adult Support and Protection Team (ASPT): For the period of (01/04/2023 – 31/03/2024), 30.37% of referrals received by the ASPT were from care homes, 448 in total. This constituted 239 inquiries and 84 investigations. Support includes reviewing care plans and care delivery, signposting to partner agencies where required and providing advice and guidance in relation to safeguarding, capacity issues and general provision of holistic care support. ASP team work closely with Care Home managers and are encouraged to make contact for advice and support regarding the submission of AP1 queries or referrals. The ASP Team have a designated care home liaison social worker who keeps in touch with the

managers and regularly visits the homes. In particular supporting new managers who are new to the area to become familiar with ASP local operating procedures and thresholds. The ASP Team work collaboratively with the nursing teams within the HSCP to undertake inquiries and investigations in order to minimise risk of harm to residents and also identify early indicators of harm prior to harm being incurred.

60. **Commissioning Team:** ER HSCP commissioning team carry out weekly welfare calls to every care home with the primary purpose to continue to build effective and positive relationships. In addition the call provides an opportunity to ensure the care home is adequately staffed, if there are any new ASP concerns, any care concerns specifically around the Out of hours period, infection control escalations and immediate or additional training requirements. The commissioning team also host a quarterly care home managers meeting which enables mangers to network, problem solve and share best practice.

61. **Advanced Nurse Practitioners:** East Renfrewshire HSCP ANPs are part of the Primary Care Improvement Plan to enhance existing medical/nursing provision and provide direct clinical assessment. ANPs provide treatment support to care home residents as required, 15.7% of ANP visits have supported care homes since April 2024.



62. **Community Rehab/ AHP** - Support to care homes is provided from Community Rehabilitation Service consisting of a link Rehab Team Physiotherapist and Occupational Therapist aligned to each care home, these staff provide regular proactive visits, every 2-4 weeks to care homes this is in addition to the specific scheduled individual assessment and rehabilitation/ support which is provided to individual residents who are referred to the team. Majority of referrals are in relation to rehabilitation to return to baseline post illness/ injury (eg #NOF)/ hospital admission. Also seating assessments to meet postural needs. The team also provide assessments and advice in relation to falls, walking aid assessments and safety checks.

63. Community Diabetes Specialist Nursing - provides in reach specialist diabetes clinical assessment, diabetic review, support advice and training to residents within East Renfrewshire care homes.

CONSULTATION AND PARTNERSHIP WORKING

64. The partnership working across HSCP teams and wider partner agencies aids the identification of themes in relation to concerns and also areas of good practice. This information sharing helps inform and guide discussions with care home managers and owners when carrying out the care home assurance visits. This ensures that areas of concern are fully shared and discussed with providers and action plans are developed to support improvement it also support sharing and celebrating of best practice across the sector. The HSCP proactively supports the objectives of provision of nursing leadership, support and guidance within care homes and has worked collaboratively to improve the health and wellbeing of people living in care homes by creating a network of health and social care multidisciplinary teams that work collaboratively with care home staff.

IMPLICATIONS OF THE PROPOSALS

65. There are no implications arising from this report.

DIRECTIONS

66. There are no directions arising from this report.

CONCLUSIONS

67. There are robust processes in place to provide assurance in relation to provision of nursing leadership support and guidance to care homes in East Renfrewshire. Additionally the collaborative support structures in place to improve the health and wellbeing of care home residents and staff and ensuring care homes are fully integrated within the health and social care system.

RECOMMENDATIONS

68. The Integration Joint Board is asked to note and comment on the report.

REPORT AUTHOR AND PERSON TO CONTACT

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5 November 2024

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS
None

Glasgow City HSCP Health and Social Care Partnership | East Dunbartonshire Health & Social Care Partnership | EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP | INVERCLYDE HSCP Health and Social Care Partnership | Renfrewshire Health & Social Care Partnership | West Dunbartonshire Health & Social Care Partnership

Greater Glasgow and Clyde

Care Home Assurance Tool **(CHAT)**

Working together with Care Homes across Greater Glasgow and Clyde, assuring quality of care and enabling care home residents to live their best possible life aligned to what matters to them.

Care Home	
Care Service Number	
Care Type	
Provider	
HSCP	
If self-review:	
Name and role of person completing record	
If HSCP and NHSGGC Assurance Visitors	
Visiting Team Name and Role 1	
Visiting Team Name and Role 2	
Visiting Team Name and Role 3	
Visiting Team Name and Role 4	
Date of visit	
Time of visit	
Name and role of person in charge at time of visit	
Details of Service	
Number of registered places	
Number of current residents	
Resident Group	
Grade and Dates of past 2 Care Inspections	
Care Inspectorate Web-Link based on Care Service Number listed above	
Date 1 *(if exact date is not known please record 1st of month)*	
Grade 1	
Date 2 *(if exact date is not known please record 1st of month)*	
Grade 2	
Note theme of requirements from last inspection if applicable	

	Question / Criteria	Yes/No	What's working well	What would make this even better	HSCP Comments
	SECTION 1: Infection Prevention and Control				
	Below are key questions to gather indicators that guidance within the National Infection Prevention and Control Manual, the sector specific Care Home IPCM and the Care Home Cleaning Specification (Safe Management of the Care Environment -SHFN 01-05) is in place within the care home.				
1	Hand rub is available at entrances and key points throughout the home to facilitate hand hygiene. Dispenser nozzles, brackets/bottle holders and bottles are clean and functioning. Staff may carry personal size hand rub dispensers.				
2	Staff comply with the essentials to support effective hand hygiene, including being bare below elbows, no stoned rings, no watches, wrist jewellery or wearable fitness devices.				
3	A supply of PPE to meet the needs of the staff and the care provided is available and close to the point of use.				
4	Reusable equipment is clean, in a good state of repair with no visible damage and ready for use.				
5	The environment is visibly clean.				
6	Residents' bedrooms and ensuite toilet facilities are clean and well maintained. If an individual resident makes an alternative choice it is documented within their personal plan and recorded as part of cleaning monitoring.				
7	Infectious laundry is collected in a water soluble bag, placed into a plastic outer bag and then into used laundry receptacle.				
8	There is a process in place for monitoring cleanliness of the care home environment to ensure standards are being maintained.				
9	The person in charge of each unit can describe the escalation process and actions to take if an outbreak (e.g. respiratory infection/norovirus) is suspected or confirmed.				
10	There is a process in place to monitor compliance with Standard Infection Control Precautions (SICPs) with results fed back to staff.				
	SECTION 1 REFLECTION				
	Based on your observations, and discussion with staff and residents, please give your professional view of the infection control measures within the care home noting how the home is managing to adhere to IPC				

SECTION 2: RESIDENTS HEALTH AND CARE NEEDS					
	This section is focused on person centred high quality nursing and social care being planned and delivered across the home. Using an appreciative inquiry approach, gathering information based on discussions, observations and the sharing of information by the home to evidence their practice. Whilst this is not an audit of resident records a selection of residents and their documentation should be discussed.				

	Personal planning (discuss a minimum of 3 care plans)	Yes/No	What's working well	What would make this	HSCP Comments
11	There are systems in place to gather information from residents, families and Power of Attorney on what matters to them.				
12	Daily notes give an indication of the quality of the residents day and demonstrate social and care interactions that align to their personal plan.				
13	Care plans are up to date with evidence of review that reflect changing needs of resident.				
14	The personal plan is accessible to resident, care team, and approved POA/ approved family.				
15	Records are dated, timed, signed and have designation recorded.				
16	There is evidence that people experience meaningful contact and activities that meet their needs and wishes.				

	Future Care Plans (Anticipatory Care Planning)	Yes/No	What's working well	What would make this	HSCP Comments
17	Future care plans (anticipatory care plans) are in place which reflect the residents and POA/ families wishes for those who chose to engage.				
18	Staff have received support or training in future care planning and feel confident in having these conversations				
19	Power of Attorney/ Adults with Incapacity is in place and in date, where required.				

	Right Care, Right Place	Yes/No	What's working well	What would make this	HSCP Comments
20	If a resident is unwell, vital signs are able to be monitored and interpreted appropriately.- e.g. RESTORE 2 / NEWS2				
21	Training and / or a system is in place to recognise deterioration and escalate concerns e.g. RESTORE 2				
22	There are adequate pathways supporting access to health care teams and they are available for residents with complex needs or condititions e.g. CHLN / DN / ANPs / GP and admissions to acute.				

	Food, Fluid & Nutrition	Yes/No	What's working well	What would make this	HSCP Comments
23	The care home uses a nutritional risk screening tool				
24	Residents food and fluid likes and dislikes are recorded within their personal plan.				
25	There is regular communication between the care team and the catering team to provide safe food and fluid for those on a specialised diet.				
26	Staff have received training and are competent in IDDSI levels				
27	Residents are prompted and assisted with food and fluid according to their assessed needs.				
28	Arrangements are in place for residents to access meals and snacks throughout the day and night. Snacks are also available for textured/specialised diet where required.				

	Continence Promotion	Yes/No	What's working well	What would make this	HSCP Comments
29	Bladder and bowel habits are recorded within residents personal plans.				
30	Staff are able to describe how to promote continence.				
31	Continence products for residents are easily accessible and topped up regularly.				
32	Is someone in the care home responsible for the assessment / reassessment of continence				
33	Have staff received training on promotion of continence				

	Pressure area care	Yes/No	What's working well	What would make this	HSCP Comments
34	The care home uses a pressure ulcer risk assessment tool				
35	The pressure ulcer risk tool is updated regularly and accurately reflects the residents changing condition.				
36	Staff are able to access pressure redistributing equipment and products to aid prevention and have been trained on how to use them.				
37	Staff have received training on pressure ulcer prevention and management.				
38	A system is in place to record pressure damage.				
39	The care home carries out a review of pressure damage to identify any new learning.				
	Falls Prevention	**Yes/No**	**What's working well**	**What would make this**	**HSCP Comments**
40	The care home uses the multi-factorial tool to assess falls risk?				

		Yes/No	What's working well	What would make this	HSCP Comments
41	The falls risk assessment tool is updated regularly and accurately reflects the residents changing condition.				
42	The home promotes and encourages movement where appropriate, to reduce the likelihood of falls.				
43	All staff have completed training on prevention of falls and have knowledge of use of equipment including bed rails, low profile beds, seating.				
44	A system is in place to report falls				
	Medicines Management	**Yes/No**	**What's working well**	**What would make this**	**HSCP Comments**
45	Staff have received appropriate training in medicines administration.				
46	There is a process in place for medication audit.				
47	Residents who would benefit from a polypharmacy review are identified and referred to pharmacy team.				
48	There is a procedure for reporting medication errors and staff can discuss learning from incidents.				
49	There is a policy/process in place for medicines returned to community pharmacy.				
50	Staff comply with Mental Welfare Commission recommendations for covert medicines administration				
	Palliative and End of Life Care	**Yes/No**	**What's working well**	**What would make this**	**HSCP Comments**
51	There is a system in place that assists recognition of changes in residents? e.g. SPAR				
52	Staff are aware of health and social care and specialist palliative care referral routes including out of hours - should this be required for residents who are at end of life.				
53	Anticipatory (just in case) medicines are available, as appropriate.				
54	Do Not Attempt Cardiopulmonary Resuscitation documentation is appropriately in place as per Resuscitation Council guidance.				
55	Staff have received training / education in the use of syringe drivers, and are competent and confident in their use?				
56	Registered nursing staff within the home are competent with confirmation of death procedures.				

	Delirium	Yes/No	What's working well	What would make this	HSCP Comments
57	Staff are able to identify a change in resident’s behaviour such as an increase in confusion, drowsiness, hypoactive or hyperactive activity.				
58	Staff are able to identify delirium and act accordingly				
59	Staff are able to respond appropriately to residents displaying stress and distress behaviours.				
60	Staff have completed training on delirium.				

	Adult Support and Protection	Yes/No	What's working well	What would make this	HSCP Comments
61	There is an adult protection policy and procedure that evidences how people are kept safe.				
62	Staff are trained in adult protection and are confident in knowing when and how to make referrals, including notifying the Care Inspectorate.				
63	Have there been any AP1s within the last 3 months?				

SECTION 2 REFLECTION
Based on your observations, and discussion with staff and residents, please give your professional view of the measures for residents' health and care needs within the care home.

	SECTION 3: WORKFORCE, LEADERSHIP & CULTURE	Yes/No	What's working well	What would make this	HSCP Comments
	This section is focused on workforce, leadership and culture within the home. Effective leadership and wider support from the organisation can be directly correlated with the care that the residents receive, how supported staff feel and the overall culture of the home.				
64	Please share any successes or celebrations your home has had in the last year				
65	The leadership team is able to describe improvements they would like to make within the home?				
66	There is supportive and visible leadership that enables staff to voice their concerns, share ideas and explore ways to promote resilience.				
67	There is effective communication between staff, with opportunities for discussion. For example shift handovers, flash meetings, clear escalation processes.				
68	Staffing arrangements allow for more than basic care needs to be met and support people to get the most out of life.				
69	Staff competence is regularly assessed to ensure that learning and development supports better outcomes for people.				
70	Staff benefit from wellbeing support that includes debriefing on the management of difficult situations, personal safety, assessment of workload and bereavement support.				

SECTION 3 REFLECTION
Based on your observations, and discussion with staff and residents, please give your professional view of the workforce,

View Agreed Improvement Priorities

Signoff for Care Home Assurance visit and accuracy of Agreed Improvement Priorities:	
Designation	
Date	