Family Nursing & Home Care

Standard Operating Procedures

Home Care Service
Client Pathway and Care Provision

March 2022

Document Profile

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Version Control / Changes Made

Date	Version	Summary of changes made
July 2021	2	Previous document transferred on to new SOP template. Content reviewed and updated in line with the Jersey Care Commission Standards for Home Care 2019, FNHC Home Care Service Statement of Purpose 2019 and FNHC Employee Handbook 2020. Document title amended due to addition of new SOPs related to Transporting of Clients (adapted from Transporting Clients Safely | Ausmed) and Safe Handling and Storage of Client's Money and Property (adapted from Supporting note: Managing money belonging to people who use services (cqc.org.uk) and Microsoft Word - Handling Service User's Money Policy.docx (chesterfieldhomecare.com))
February 2022	2.1	Further revision post consultation with Home Care Manager

Contents

Introduction

These Standard Operating Procedures (SOPs) have been developed to guide the practice of staff working in the Home Care Service provided by Family Nursing & Home Care (FNHC).

The Home Care Service (the 'Service') aims to provide a consistently high-quality service and is supported by a robust governance framework and clear planning, admission, assessment, care delivery and discharge processes. A package of care which is adequately planned and prepared promotes safety for the client, reduces the risk of re-admission to hospital/placement, and a much improved chance of a successful and long-term care package.

Home Care Services are provided in accordance with the Jersey Care Commission Standards for Home Care.

According to the Home Care Service Statement of Purpose the aim of the Service is to support people who due to illness or disability are unable to sustain their desired level of daily living without assistance.

The Service provides assistance to enable people to remain in their own homes and achieve their potential in relation to physical, intellectual, emotional and social capacity. This can include personal care, meal preparation and monitoring, companionship, support to access social activities, medical appointments, care for pets and household duties.

The Service is informed by an outcome based approach that provides services that meet client stated outcomes rather than 'completing tasks', which gives the client better choice and control over how care and support is delivered.

The Service supports individual clients to enable them and focus on individual goals expressed by the client and in collaboration with the Multi-Disciplinary Team and those who support them.

The Service is client centred and directed by their individual needs and preferences. The focus is on:

- Enhancing quality of life
- Delaying and reducing the need for care and support needs
- Ensuring people have a positive experience of care and support
- Safeguarding adults whose circumstances may make them at risk of abuse and protecting them from harm

SOP 1 Referral Process

Purpose

To promote safe management of referrals into the Service and ensure clients who meet FNHC Home Care criteria are accepted onto the Service via a robust referral process and other referrals are re-directed to alternative sources of care or support.

Scope

All patients referred to the Home Care Service from a range of sources

Core Requirements

- When an enquiry for provision of home care services is received from either the individual, their family member or a social worker commissioning a package of care, an enquiry form will be completed and the Home Care Service Registered Manager (RM) will check/assess resources to determine if the care package requested can be provided

- The Home Care Service will have availability to accept a referral if there are:

    - Appropriately trained and competent (or could be trained and assessed as competent) Care Assistants (CA)/Senior Care Assistants (SCA) available to provide client visits at the requested time and for the requested length of time

    - CAs trained in advanced skills e.g. PEG feeds, bowel care, if this is required as part of the care package

    - SCAs available to provide assessment and care planning.

- If the Service is unable to meet the needs of the individual due to lack of availability, they can be directed to the list of Registered Providers so that they may explore other options and to the Single Point of Referral (SPOR) Team for an assessment of their needs and funding.

- If the Service has availability to commence the care package an initial assessment date and time is agreed. The initial assessment will be undertaken by the RM or their delegate as appropriate.

- New assessments not undertaken by the RM will be reviewed by them prior to care commencing.

- Where risks or unmet needs are highlighted as part of the initial assessment these will be discussed with the referrer and risk assessments completed and package requirements reviewed as appropriate.

- Where risks are not able to be safely managed by the Service then consideration will be given to declining the package of care.

- If the package of care is being commissioned by Health and Community Services then a joint visit will be undertaken with the social worker or a member of the Long Term Care team. The client should be made aware at this stage that there may be additional costs to them that may not be covered by Long Term Care funding.

- Once a referral has been accepted and confirmed in writing, the referrer/commissioner must then forward a completed referral form with all relevant details documented i.e. summary of their care assessment and care plan.

- Most of the new clients referred to the Service will have high-level or nursing needs & have received assessment from a Health & Social Care professional(s), for example, Social Worker, Physiotherapist, Occupational Therapist, Continuing Care Nurse etc., and the outcome of this assessment should be forwarded to FNHC Home Care. The Referrer should also identify if the client has been assessed for Long Term Funding (LTF) and where invoices should be sent

- Written referrals will be accepted in the following formats:

  - ✓ Completed FNHC Home Care Referral Form

  - ✓ Completed SPOR (Single Point of Referral) or alternative Referral document

  - ✓ Personal Support Plan (PSP) provide by Social Worker

- If a client contacts the Home Care Service directly for care provision their request will be screened and if appropriate they will be offered an initial assessment or informal meeting to discuss the range of services available.

- A visit to the client's home will be required prior to confirming the care package, to assess the home environment and risks

- If FNHC Home Care has the resources to accept the referral and provide the care requested, this will be confirmed with the referrer by an appropriate method i.e. email, telephone, face to face, detailing the exact care which will be provided, i.e., the time of visits, number of carers needed, the time and duration of each visit and the cost of the care package.

- For private clients the hourly rate is agreed with them and confirmation of person responsible for managing financial affairs for invoice and payment.

- Every effort will be made to provide the care package as soon as possible but only if there are adequate resources to ensure a safe admission into the Service. The Service will not be pressurised into rushed discharges from hospital.
- The Service will not accept referrals for existing clients, discharged from hospital into our care, if their care needs have changed and the care package requires an increase, without a reassessment.

- The Service will not accept new referrals on a Friday if there is an expectation of the care commencing immediately or over that weekend. The only exception to this is clients who have been assessed as red or amber on the Gold Standards Framework (GSF), whose preferred place of death is their own home and agreed in conjunction with the District Nurse team.

SOP 2 Admission Process and Initial Assessment

Purpose

To promote a robust planning and admission process for clients accessing the Home Care Service and to provide a comprehensive and appropriate initial assessment. This will record client's current function/needs, ensure that client's needs/goals/risks have been identified and a management plan is in place to meet such needs/goals/risks, and to inform future re-assessments where changes will be identified and escalated to the appropriate agency.

Scope

All clients accepted by the Home Care Service who will be receiving a FNHC care package.

Core Requirements

- The RM/SCA will receive a completed Assessment/Care Plan/Referral Form from the designated Referrer. Further information should be obtained if possible from discussion with other agencies involved, discussion with the nurse caring for the client (if in hospital), the G.P and with the client and/or family.

- If the client is new to FNHC and has complex needs, it is essential to observe any specific procedures needed on discharge, e.g., transfers with prescribed equipment.

- The RM/SCA should aim if possible to attend any Access Visit or Home Visit prior to client's discharge, along with the Multi-disciplinary Team (MDT) e.g. O.T., Physiotherapist, CCT etc.

- Any equipment needed will be assessed by the MDT and must be put in place prior to commencement of the care package.

- If the RM/SCA does not agree with the appropriateness or safety of any equipment or procedure their concerns should be raised with the MDT.
  FNHC will decline acceptance of a client if safe procedures are not in place.

- With the information obtained from the above process, FNHC Home Care Service documentation can be commenced prior to client's admission to the Service.

- The initial assessment will normally be carried out by the RM or SCA at the first planned visit and should build on the information gained during the planning process.

- All sections of the Assessment Tool should be completed along with the following supplementary tools:
  - ✓ Pressure Ulcer Assessment Tool (Waterlow; PURPOSE-T)
  - ✓ Falls Risk Assessment Tool (FRAT)
  - ✓ Nutritional Screening Tool (MUST)
  - ✓ Medication Assessment Tool (see Home Care Medicines Policy)
  - ✓ Lone Worker Staff Safety Checklist
- If the client has a Waterlow Score over 10 and/or is at risk of skin breakdown, a specific care plan should be completed plus a skin bundle.
- If the client has a history of, or is at risk of falls, the FRAT should be completed. For any identified risk, action taken should be documented on the FRAT form. If there is no space on the FRAT form, write 'see communication' and complete details of action in communication section of the records. Refer to the FRAT Guidance Sheet for action required. The SCA is able to manage the risk if the action required is giving advice to the client or minor adjustments such as removal of rugs etc. Otherwise a referral is likely to be needed e.g. to GP, OT, Physiotherapist, Falls Clinic, Community Rehabilitation Team or Key Worker. (SPOR referral required except to GP)
- If client has a Nutritional Score of 7 or above, a management plan should be documented on the back of the Nutritional Screening Tool. The client may require referral to the Dietician as nutritional supplements may be needed.
- If a client has a diagnosis of dementia or has mental health issues, it should be confirmed that the GP, Key Worker and/or Mental Health team are aware. This should be considered when planning care for the client and CAs should be made aware of the client's diagnosis.
- If a client has continence issues which have not already been assessed, a referral should be sent to the appropriate DN team requesting a continence assessment.
- The management plan for administration of medication should be documented on the Medication Assessment Tool (e.g. self-administration, family support). Should a client require prompting or administration of medication, refer to the FNHC Home Care Medicines Policy.

- If mobility or safe handling needs are identified on the moving and handling risk assessment, an urgent referral should be sent to OT/Key Worker requesting assessment of equipment needs. This could be a joint assessment with FNHC if the Home Care Service have staff availability to attend, but will not always be possible. Referral should be by a telephone call due to urgency of matter, followed by an e-mail to confirm and by a SPOR referral if requested.

- If it is considered by the MDT that client is in his/her last year of life, the appropriate District Nurse team should be informed to enable client to be discussed at the next Gold Standard Framework meeting.

- Within the first two visits to client, a copy of the Service Contract should be given to the client, listing visiting times, costs etc. A signed Service Contract constitutes the client agreement to the conditions of the care package. (This will also include charges incurred if client is admitted to hospital or a period of respite). A copy of the Contract should also be sent to the Commissioner of the client's care if appropriate.

- The following information should be given to the client and explained:

  - ✓ FNHC Home Care Service leaflet
  - ✓ Comments, Compliments & Complaints leaflet
  - ✓ How We Use Your Information leaflet
  - ✓ Preventing Pressure Trauma leaflet
  - ✓ CROMS (Client Reported Outcome Measures) questionnaire (discharge support clients only)

SOP 3 Care Planning for Home Care Clients

Purpose

To promote clear, precise and unambiguous care plans which enable safe and effective care delivery.

Scope

All Home Care clients receiving a care package

Core Requirements

- All care plans should be discussed, negotiated and agreed with the client, as stated in each care plan template. The written contract will also state that client is consenting to care plans held in the home-held records.

- Care plans should be goal-centred and client-specific and should reflect the individualised client goals as identified on initial assessment. However, it must be acknowledged that to achieve certain goals, some procedures or 'tasks' may need to be performed by a CA skilled in such procedures, e.g. catheter management.

- Each plan should contain client's goals/need in all appropriate areas, e.g. continence, medication, skin care etc. The CA should re-read the care plan prior to leaving client and ensure all tasks have been completed to the client's satisfaction.

- Care plans do not need to document aspects of care which would be expected as standard practice for CAs e.g. wearing apron and gloves, ensuring dignity and privacy for clients.

- Care plans will be written up by the RM/SCA following the planning and assessment process, including use of pre-printed care plans where appropriate, e.g. for equipment.

- A care plan index should be completed and all care plans must be signed and dated by the author, and client whenever possible.

- Instructions in care plans should be clear and simply stated and typed to promote ease of reading and understanding.

- A care plan should be written as a 'checklist' for each CA visit, e.g. there should be a separate plan for morning/lunchtime/afternoon/twilight visits. Each care plan should state the length of the time allocated for the visit and the CA will be expected to remain with client for that length of time (also see SOP 5).

- Each care plan should contain instructions regarding client's mobility e.g. use of Zimmer frame, wheelchair.

- A separate care plan will be needed if client needs assistance to take prescribed medication, as per FNHC Home Care Medicines Policy.

- When a client requires specific equipment for safe handling they will need:

  - ✓ a completed moving and handling risk assessment

  - ✓ a separate Safe Handling Care Plan which lists client's specific needs, e.g. hoisted onto bed in lounge etc.

  - ✓ a pre-printed generic care plan for each piece of equipment

  - ✓ a completed sling form if appropriate.

- The Manufacturer's Manual for each item of equipment should be supplied by the equipment provider and should be easily accessible in client's home.

- Hand-written additions to care plans are permitted and must be signed and dated. Any additions must be notified to the RM/SCA.

- If there are more than two additions to any one care plan, the plan should be retyped as soon as practically possible, a line scored through the old care plan and the discontinued care plan filed at the back of the hard copy records.

- If a care plan is discontinued, a line should be drawn through the care plan, dated and signed, and the plan should be filed at the back of the records.

- Clients care needs/care plans are reviewed at least every six months to reflect any changes in their care needs or emerging risks. If the review is completed by the SCA the RM will need to be advised of any significant changes/risks and actioned appropriately.

SOP 4 Record Keeping for Home Care Clients

Purpose

To promote clear and accurate record keeping and ensure client information is kept updated, safe and accessible. To promote fast and accurate statistical analysis of Home Care service when needed.

Scope

All clients in receipt of the FNHC Home Care Service.

Core Requirements

- On admission to the Home Care service, the following client details will be entered onto CarePlanner® and must be kept up to date:

  - ✓ name & address
  - ✓ date of birth
  - ✓ URN number
  - ✓ Case Manager/Key Worker
  - ✓ GP
  - ✓ visit times and days of week
  - ✓ if client receives domestic support
  - ✓ long-term care funding status
  - ✓ key pad number for property access
  - ✓ diagnosis
  - ✓ allergies
  - ✓ identified environmental risks
  - ✓ last re-assessment date
  - ✓ re-assessment date due
  - ✓ DNACPR status

- A list of key pad numbers should be kept separately so the key pad number is not documented with the address.

- Each client will also have a completed set of hard copy records which will be kept in their home whilst the client is in receipt of the Home Care Service.

- If the client and GP have signed a DNACPR Form this should be filed at the front of client's records (with the client's consent). The client's DNACPR status should be documented on the Home Care spreadsheet and the Base Card and the expiry date of the DNACPR also noted. Once the DNACPR Form has expired, discussions should follow with the GP and/or DN regarding renewal of the DNACPR or otherwise. All staff visiting the client must made aware of the client's DNACPR status.

- It is essential that where equipment is used with a client, the 'Equipment List' form is completed accurately, including who to contact should the equipment malfunction. Clients remain responsible for the provision and maintenance of such equipment.

- All information, referrals, letters etc. concerning the client should be filed in the hard copy records.

- An electronic record will be kept in the office for each client in order to document non-visiting interventions e.g. telephone calls, reports from CAs. This will include any issues which could potentially lead to safeguarding concerns. Entries should be brief and factual and not contain speculative or subjective comment.

- Each CA and SCA will complete CarePlanner® following each visit, to facilitate an accurate billing process and provide statistical evidence for the Home Care service.

SOP 5 Delivery of Service to Home Care Clients

Purpose

To ensure that clients receive a service that is client-led, individualised, safe and effective

Scope

All clients in receipt of the FNHC Home Care Service.

Core Requirements

- For new care packages or changes to care, the CAs should be supported to become familiar with the client's needs, particular in relation to equipment/safe handling.

- The SCA should meet with CAs at the client's home to demonstrate transfers etc. until the SCA is satisfied that all the CAs are fully competent in the safe handling procedures for each client.

- When a client is new to the Service or their needs have changed, the CAs will be kept informed of any changes/updates via the CarePlanner® messaging alert system and/or via telephone calls from the RM/SCAs

- CAs should adhere at all times to the Code of Practice for Health and Social Care Support Workers in Jersey (2018).

- CAs will log in and out of CarePlanner® on arrival and departure and should remain in the client's home for the designated time. However if the client requests them to leave early this should be documented in the client's care record.

- The CA should deliver all aspects of the care plan thoroughly and efficiently and check again at the end of their visit that all procedures listed on care plans have been completed. If care plans cannot be completed for any reason, this should be documented and reported to the SCA.

- If CAs are uncertain about the service required or the care plan is unclear, they should check with the SCA/on call before providing care.

- If the CA is not familiar with a piece of equipment or a task required by the client, they should not proceed. They should inform the SCA/on call, who will arrange for themselves or another carer to visit, to deliver the care required.

- All care given must be documented as per the FNHC Record Keeping Policy.

- It is essential that the care plans are followed at all times and no care is provided which is not documented in a care plan. If the CA has concerns that client's needs are not being met, this should be reported to the SCA/on call.

- All staff are responsible for alerting an appropriate manager, without delay, to any concerns, suspicions or evidence of abuse/neglect/exploitation that they observe and/or hear about, as per the FNHC Safeguarding Policy. Such concerns should NOT be recorded in the client's home-held record but instead will be documented in the client's electronic record by the RM together with the member of staff raising the safeguarding concern.

- The SCA must respond to any concern reported by the CAs, in order to appropriately manage any risks/concerns. This may entail a visit by the SCA or a referral to another agency. The nature of the response will be a clinical judgement by the SCA. The following is a guide only: -

    - In an emergency an ambulance should be called & the CA should be advised to remain with client until the emergency services have arrived

    - If a client is acutely ill, the GP should be contacted by the SCA. The SCA should confirm that the GP will be visiting and if client declines a GP visit, the SCA should discuss with client and with senior staff if needed. It is not adequate to request that a family member calls the GP. It must be documented that the GP has been called and expected time of visit.

    - If a client has a nursing need, e.g., a blocked catheter; skin laceration, a referral should be sent to the geographical District Nurse (DN) team.

    - If a client develops continence issues, a referral should be sent the DN team for a Continence Assessment. A referral should also be sent to the DN team if the prescription for continence pads (if client receiving subsidised products) needs to be renewed.

    - If a client's needs have changed and a review of their care package is needed, an urgent re-assessment requested by the relevant Health/Social Care Professionals via a SPOR referral

    - If equipment prescribed is no longer appropriate for the client or is unsafe, an OT referral should be sent to SPOR. The SCA can provide a joint assessment with the OT when equipment needs are assessed or re-assessed, but the SCA is not expected to assess for equipment alone.

- If a pressure ulcer or skin breakdown is identified or suspected, the SCA should visit the client and initiate a management plan/SSKIN bundle as appropriate and refer the client to the DN Team for assessment. Any pressure ulcers Grade 1 or above must be entered on the ASSURE incident reporting system.

- If the client is unwell or their needs have changed suddenly, and the equipment/care package is no longer appropriate, consideration should be given to a referral to the Rapid Response and Reablement team (RRRT) This action should be discussed with the client's GP and it will be the GP or District Nurse who will make the referral. Acceptance by the RRRT must be confirmed.

- Any referrals or escalation of concerns must be agreed with client and documented in the records.

- SCA must be aware that if there are signs of abuse or neglect reported or identified, which may constitute a potential safeguarding concern, this should be discussed with the RM or Safeguarding Lead.

- The SCA is responsible for re-assessment of clients. Re-assessments will occur if problems or risks are identified or if client has had a period of time in hospital. If no unexpected issues arise, each client should be reviewed approximately 6 weeks after a care package is set up. Thereafter each client should be reassessed at least every six months.

- On re-assessment of client, the assessment tool should be used to identify any changes and all care plans re-assessed and re-written if needed. If care plans remain unchanged, they should be signed and dated at the time of reassessment.

SOP 6 Transportation of Home Care Clients

Purpose

To ensure that when Home Care Service clients are being transported by staff both they and staff are kept safe and protected from harm

Scope

Home Care Service clients who may be transported by Service staff as part of their care package.

Core Requirements

- A care plan and risk assessment must be completed by the SCA prior to transporting clients, including the following considerations:
    - The vehicle being used and its suitability – number of doors, seat height and comfort, seat belts/restraints, adjustable heating and ventilation, cleanliness, free of clutter
    - The client's level of mobility, ability to get in and out of a vehicle and any aids used/required
    - The client's mental state and ability to consent eg if any potential for their behaviour to interfere with the driver will need escort
    - Infection control eg requirement to wear PPE
- The client's package of care should reflect the costs or mileage paid to staff member when using their own car
- Any staff who use their own vehicle whilst on FNHC-related business eg transporting clients, will be required to complete an annual declaration giving details of their vehicle registration, make and model; driving licence and motor insurance (see FNHC Employee Handbook and FNHC Health and Safety Policy)
- Staff must ensure that their motor policy covers them for business use
- Staff must ensure that their vehicle is kept in a roadworthy condition and is reasonably clean and presentable. Staff must refrain from smoking both prior to and during transportation of clients. Where necessary staff will be provided with protective equipment when using their own vehicle eg seat covers.
- Staff must ensure that they drive within the road traffic law and follow the Highway Code.
- The HR department must be informed of any road traffic collisions occurring whilst on FNHC-related business or any disqualification or potential disqualification from driving

SOP 7 Safe Handling and Storage of Home Care Clients Money and Property

Purpose

To ensure that where required Home Care Service client's money and property is handled safely and securely, to protect them from possible financial abuse and also protect staff from false allegations of misuse

Scope

All clients in receipt of the FNHC Home Care Service.

Core Requirements

General principles:

- Staff should ensure that clients retain effective control of their own money and property in all cases, except where it is explicitly stated that they require aid. Clients should be encouraged to keep money and valuables in a secure place at all times and not to leave money or valuables lying about.

- Staff must ensure that client's financial information is kept confidential

- Staff must not discuss their personal financial situation with clients, offer financial advice to clients or enter into any personal transactions with clients

- The client's wishes and their ability to manage their finances will be assessed as part of the admission process and any concerns will be fully discussed with the client/relatives, GP and/or social services/key workers as appropriate.

- A description of the exact help they will need, if any, will be documented in their care plan and reviewed on a regular basis.

- Existing clients who have difficulties dealing with their finances or with money should be offered support and help by the Service only following a re-assessment of their condition and with the explicit agreement of the social services key worker/GP involved. All such agreements should be recorded in the plan of care.

- Where the money of individual clients is handled by staff eg during accompanied shopping, unaccompanied shopping, collecting pensions, paying bills etc, they should check and keep all receipts along with any other written records of transactions.

- The amount and purpose of all financial transactions undertaken on behalf of a client, including shopping, should be recorded appropriately using a triplicate receipts book. Each entry must be signed and dated by the CA and checked by the client, if able to do so, or their relative or representative on their behalf as appropriate. The client will retain one copy and a copy will is available for the delegate for the client's financial affairs, where one is in place.

Handling Cheques and Cash:

- In the absence of family, staff may be asked/required to write a cheque on behalf of a client; this is to be documented in the care notes and written permission gained. The cheque is to be written in pen exactly to the client's instructions in the presence of the client, and the client must sign the cheque

- Where a cheque is to be used for paying a bill, a receipted invoice will be obtained for the amount paid and this receipt returned to the client as before.

Loyalty schemes/discount cards

- The use of loyalty schemes such as Co-op accounts is permitted where the account is opened in the name of the client and they are used to accrue benefits for the client when they spend money from their own account. Under no circumstances may staff members receive any benefit from a loyalty schemes through spending made by a client

- In some instances a staff member may have access to discounts (through a discount card or similar) which can be used for clients. This is permitted where the staff member does not accrue any benefit to themselves as a result and where it would not be a breach of the terms and conditions of the discount provider.

Acting as an Executor of a Will

- Under no circumstances are employees to act as an executor to or give a signature of witness on, a client's will. Failure by employees to follow this clause may result in disciplinary proceedings being taken and may also result in a case of personal litigation if following the death of a client the family decide to contest any form of will or gift made to an employee, and to that end no responsibility for liability will be accepted by FNHC on behalf of the employee.

- If an employee has reason to believe that they are a beneficiary of a client's estate, they are required to inform their RM immediately.

Witnessing a client's signature

- From time to time documentation pertaining to a client may need countersigning; this documentation would normally be from a social security department, parish or other welfare/health department. In cases where a signature of witness is required then the employee should contact the RM for advice in the first instance. FNHC operates a policy that does not allow any employee to witness signatures. Any deviation from this clause may result in disciplinary procedures being taken.

Gifts and Inducements

- It is the RM's responsibility to explain to the client that it is FNHC policy not to accept gifts; however, it is permissible for employees to suggest to clients that they can make a donation to the FNHC charitable fund.

- Should employees be offered gifts they should explain politely to the particular client that they are not allowed to accept gifts. If the client is distressed and/or determined that the employee should receive a gift, the employee should declare this to the RM as soon as is reasonable practicable and details recorded in the client's electronic record.

- Employees must not under any circumstances, borrow from or accept a legacy whether in monetary form or otherwise from any client, former client or potential client of FNHC; or without prior authorisation of the Chief Executive and committee, enter into any transaction of any kind which provides personal benefit to an employee by reason of employment by the Association; or accept or offer gratuities, hospitality, corporate entertainment, financial or other inducements (as per FNHC Employee Handbook).

Reporting Concerns

- Any member of staff who suspects that a client may be being cheated, defrauded or robbed, whether by a member of staff, family or others, or that a client is no longer capable of managing their own finances should immediately report their concerns to the RM/SCA.

SOP 8 End of Life and Palliative Care

Purpose

To identify clients who are potentially in the last year of life and promote high-quality palliative care to clients and their family when clients have palliative needs or are on the end-of-life pathway.

Scope

All Home Care clients who have palliative or end-of-life care needs.

Core Requirements

- The SCA should aim to identify any client who, because of a diagnosis of a terminal illness, the last stages of a long-term condition or increasing frailty and loss of function in advanced age, may be in the last year of life. Once the client has been identified, the GP and DN team should be notified so the Gold Standard Framework (GSF) can be implemented.

- Clients who are identified as potentially in the last year of life or have a long-term condition which is unstable or symptomatic, should be referred to the DN service. SCAs will not have the clinical knowledge or resources to continually respond to concerns which arise around unstable conditions. Escalation of problems with this client group should be to the designated DN team.

- FNHC should aim to accept any client managed by the DN team and/or Hospice who requires end-of-life care. As this is likely to be a short-term care package, every effort should be made to accommodate such clients within the Service.

- A personalised care record for the last days of life will be used as the care plan and symptom management when patient is coded red on the GSF. This will be instigated by the GP/DN and managed by the DN team. They will write all care plans which are likely to change from day to day. (Alternatively changes to care may be documented in the communication sheet and the CAs must be made aware that the communication sheet must be read). Frequent liaison between CAs and the DNs should be encouraged and the SCA may not be required to intervene with these clients.

- Care plans for use of equipment with end-of-life clients should also be written by the DN Team, as the Nurses will be fully aware of client's symptoms, pain levels, moving and handling issues etc.

SOP 9 Discharge from the Home Care Service

Purpose

To promote safe and appropriate discharge of clients from the Home Care Service.

Scope

All clients discharged from the Home Care Service.

Core Requirements

- Ensure all relevant sections of the Client Records are complete (hard copy and CarePlanner®)
- Complete GP Liaison Letter and where relevant copy in any relevant services involved in client's care. File GP discharge letter in Client Records
- Discontinued care plans should have a line drawn through them and they should be dated and signed.
- The reason for client's discharge from the service should be documented in the Communication sheet and in the Significant Events section. If client continues to require care, the name of the new service provider should be documented, e.g. family, nursing home.
- All records should be returned to Le Bas for archiving.
- All office-held/hard copy notes should also be filed in the Client Records and archived at Le Bas