Haringey Council

Appendix 2

GUIDANCE

FOR

CLOSURE

&

TRANSFER

OF

VULNERABLE/FRAIL RESIDENTS

RESIDENTIAL CARE HOMES

Document Reference:			
Author(s):	Len Weir and Beverley Tarka		
Issue No:	One	**Issue Date:**	1/08/11
Version No:	V0.1.	**Authorised By:**	Lisa Redfern
Review Date:	1/04/12		

CONTENTS **PAGE**

1.0 **INTRODUCTION**

The primary aim of this Best Practice guidance is to ensure that when a decision has been made to close a care home, the needs of residents, their relatives and others are met as far as possible, and that efficient and effective actions are taken in response to their individual circumstances and needs.

Underpinning this guidance are local and national experience, 'best practice', research, government circulars, statue, regulations and case law. Several sources of useful information are listed at Appendix 1 to this Guidance.

A coordinated response and effective partnership working can ensure the well-being of residents, their representatives and staff.

This guidance is between London Borough of Haringey, NHS, voluntary and independent sector partners and colleagues and the Care Quality Commission (CQC). Throughout the document these are referred to as the Local Authority, NHS, the voluntary and independent sector and CQC.

This guidance is provided to support the transition process which follows any decision to close or decommission a residential home for vulnerable people in or cared for by the Borough.

The process of closing a care home is complex, protracted and one which can potentially cause anxiety and stress for residents, relatives and staff alike. It therefore needs to be approached with care and sensitivity and undertaken in a dignified and a humane way. This guidance aims to provide a mechanism to support people through the closure and transfer process.

It also aims to ensure the protection of vulnerable adults at all times and that people are treated humanely and with dignity and respect (Dignity Guidance).

2.0 PRINCIPLES AND RIGHTS

The well-being, needs and rights of vulnerable adults are paramount. This cannot be assured without appropriate communication and consultation with users of services, next-of-kin, carers and other formal and informal representatives of people who use our services.

Appropriate communication must take into account the language and communication mode appropriate to the individuals involved (language, sensory and other impairment needs etc). Where possible, information should also be made available in accessible formats.

Consistent and timely communication with all involved parties is necessary, as are comprehensive records and notes of what has taken place.

Consultation with others about them is subject to obtaining informed consent from service users. Where an adult is unable to consent or make important decisions because of mental incapacity, the Mental Capacity Act 2005, its code of practice and regulations should apply to financial, serious health treatment and accommodation decisions.

Self-funders should be entitled to the same advice and assistance as other adults funded by statutory and voluntary organisations.

Agencies should work together cooperatively and take account of the following principles when relocating vulnerable adults and be mindful of the relevant key principles and objectives of the Haringey Compact in terms of effective working with statutory, voluntary and private agencies:

- Safety
- Safeguarding
- Minimising distress and disruption of services
- Dignity
- Choice
- Least restrictive options
- Respect for family life
- Equality and Diversity
- Privacy
- Realising Potential

It is acknowledged that multiple moves can be disruptive for individuals and their families and these should therefore be avoided unless there are extenuating circumstances that make them unavoidable.

The importance of protecting friendship groups when planning and actioning new placements for residents should be recognised and individual and group preferences accommodated wherever practical.

All agencies operate within the boundaries of resource constraints. Realistic expectations and planning should make best use of available resources.

2.1 COMMUNICATION WITH RELATIVES, FRIENDS AND CARERS

- Communications with relatives, friends and carers should be conducted on an individual resident by resident basis [correspondence, updates and, face-to-face once the decision to close a residential care home has been made].

- Residents' personal histories should form part of the information transferred when they move from the originating home to any new setting and where possible, relatives should be involved in providing this information – this is also to include likes and dislikes/preferred names etc.

- Generally, relatives, friends, carers and advocates (where identified as required) are to be involved throughout the managed closure period.

Prior to decisions being made, consideration should be given to the impact upon carers and vulnerable people (and be a part of the consultation, equalities and other impact assessments that form part of the decision-making)
Monitoring and review of the well-being of vulnerable adults should be undertaken at appropriate intervals, and should underpin the identification of good practice and lessons to be applied in up-dating of this Guidance and our procedures.

3.0 OVERALL MANAGEMENT OF THE CLOSURE AND TRANSFER

Any closure and transfer should be treated as a project and adopt 'project management principles' and be overseen at the appropriate senior management, Board level (e.g. Divisional Management Board). The group should meet fortnightly (monthly at the outside) and other members should include the appropriate service and specialists (Director/Deputy Director, Heads of Service, HR, Business Support, Finance, Press & Communications, Consultation, Equalities, Legal etc) in order to discuss relevant matters (risks and issues) and review progress leading up to, during and after any closure and transfer.

The appropriate Board should take all key decisions, including agreement that this Guidance has been fully adhered to before any transfers take place.

A 'named person or persons' should be responsible for overseeing the project on a day to day basis from conception to completion – reporting to the Board and supported along the pathway by individuals with identified roles within the various work streams as appropriate to the stage or stages of the project.

The Board shall ensure oversight of the project/programme throughout the closure and transfer and a formal evaluation/review should take place 6 weeks after the transfer of the final residents.

There should be a designated individual for the home(s) in question to whom staff and others can turn with their concerns if they believe that the process is not being handled sensitively or appropriately.

An overall project plan including key milestones should be produced.

A risk register and issues log should be produced and updated as required.

A project initiation document (PID) should scope the range, outcomes and outline business case as appropriate.

Table 1 – Illustrative time line for key activities.

Activities (month)	1	2	3	4	5	6	7	8	9 etc
Communication									
Project planning									
Consultation with residents/families									
Consultation with workforce									
Risk assessment									
Equalities impact assessment									
Identification of jobs at risk and issuing redundancy notices									
Individual support planning meetings/ exploring options									
Individual meetings with staff: relocation/ redundancy									
Staff skills development/time off for job seeking									
Medical/nursing assessments									
Visits to potential new homes/staff visits									
Decisions about moves									
Closure events – party, memory books etc.									
Identification and securing of property									
Coordinating moves									
Staff leaving									
Facilities/property security and closure									
Monitoring and follow up of process									
Lessons learned from process									

4.0 CONSULTATION

Consultation and decision-making should be as open and transparent as possible. See the Council's Consultation Charter Residents and relatives and others stakeholder/stakeholder groups directly affected must be involved throughout.

Neither should be rushed and must be genuinely entered into, with face-to-face contact explaining the reasons for closure among the means of effective consultation employed. Residents should be offered an advocacy service (and access to legal advice) where they have no friend, relative or carer to speak on their behalf.

The timing and manner of breaking the news to residents is also critical. Using the analogy of bereavement, people should be allowed to go through the various stages such as shock, denial, anger and finally acceptance with skilled staff and others on hand to assist individuals through this. Residents' families or close friends may also have feelings of guilt and anxiety and may need special attention. Building in enough time through the stages is crucial. The local authority should keep people well informed every step of the way, making sure the residents, relatives, advocates and staff are among the first to know of any developments. They need to be told the facts in a straightforward way, without bad news being couched in language intended to soften the blow, if this could be perceived as patronising.

Consultation is a partnership in the decision-making process. In having their say, those involved can share in how and what decision is made and the shaping of any future or alternative provision.

> "In any context the essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice"

There are four minimum requirements of consultation

- It must be when proposals are still at a formative stage
- Sufficient information must be given to permit informed consideration and response
- Adequate time must be allowed for the consultation
- Consultation must be meaningful and conscientiously taken into consideration in reaching decisions.

Even when there is no statutory requirement to consult, there is likely to be an expectation of doing so, either because of a promise/past practice and/or because of the interests involved (at any rate in the case of residents and staff).

Consultation can be on a preferred or 'in principal' option. If there is an amended proposal arising from responses to the consultation, there is no need to start the consultation process again (i.e. views have been listened to). If however, it is a 'new' proposal, then there will be a requirement for further consultation. Whether a proposal is an 'amended' one or a 'new' one requires advice from the Local Authority's legal and consultation experts before any action is taken.

Residents of homes or people who use our service have a right to be consulted about proposals which affect their support and care service, even where it may cause them distress to do so. This is relevant particularly for people with learning disabilities where carers have argued that residents should not be informed about options because it would 'upset them considerably'. The argument has also been made about the residents of homes for older people.

What is important to consider is the timing of the consultation, how it is communicated and handled so that distress is minimised and support is given to residents and people who use our services throughout.

Consultation is not a 'process'. A 12-week period of formal consultation should be used to include residents and carers, general public, stakeholders and staff and Trade Unions.

A detailed account should be maintained for analysis and reported to inform decision-making and should be made available to relevant stakeholders.

A dedicated team of experienced, and specially trained social care staff should be established to support and offer advice to residents and their families throughout the entire period.

The dedicated social care worker would complete the consultation with residents and their family members on the proposals relating to home closures. The purpose of the consultation is to give residents, relatives and carers, the opportunity to contribute their views/suggestions on the proposals.

Throughout the consultation, consultees should be advised of the timescales involved and it should be stressed that no decision has yet been made.

Consultation with others about an individual is subject to obtaining informed consent from people who use our service. Where an adult is unable to consent or make important decisions because of mental incapacity, the Mental Capacity Act 2005, its code of practice and regulations, should apply.

IMCA services should be accessed to support residents without mental capacity and who have no next of kin or advocates. Advocacy support would be available.

5.0 **RISK ASSESSMENT**

Risk assessments in relation to the transfers should be completed on an individual basis as part of the assessment process in the run up to the transfer to another home and should involve relevant professionals, including health staff. Consultants in Old People's Medical and Old People's Mental Health to provide appropriate clinical assessment and oversight to support residents and staff during the transition planning process. However, there are some general risks which can be foreseen and actions taken to minimise the impact of any transfer on older people.

(i) There is likely to be greater risk for people with severe dementia/confusion and in particular for those people who are extremely frail and have co-existing medical illnesses. As an example (but not exclusively) these would include heart and lung disease, Parkinsons, previous breakdown, great age, male gender, liability to falls/reduced mobility, incontinence, impaired vision/hearing, anxiety/depression/paranoid thoughts, obesity, multiple medication and a history of chest infection (and/or combinations of the above).

Action required: medical examination initial assessment and also immediately prior to any proposed transfer (if indicated) will be important as part of the individual risk assessment and should indicate whether a resident is fit to transfer and any additional precautions which may need to be taken.

(ii) Residents who need particular pieces of equipment (e.g. special mattresses in order to have adequate care) may be at an increased risk.

Action required: a review of the equipment needs of any residents transferring to a new home should be undertaken and no resident should be moved until the receiving home has in place the required equipment and where necessary staff have received training in its use.

(iii) Residents with special dietary needs, particularly those who may need assistance with feeding (for whatever reason) may also be at increased risk.

Action required: that these individuals are identified and their support plans fully reflect any assistance which may be required in this area. In addition, named care staff from the receiving home should be fully briefed and trained on any particular skills which may be required. A transition form/checklist

should accompany the resident to the receiving home to ensure all identified information requirements are in place. This may be effected by staff from the current home “in-reaching” to discuss matters with the receiving homes staff.

(It is not possible for London Borough of Haringey staff to move with residents to private care homes except to transfer and offer support on arrival to settle in.)

(iv) Generally, the up-to-date knowledge of an individual’s medical condition and their fitness to transfer is key, as is the handover between one medical practitioner and another.

Action required: up to date medical and nursing evaluation (see below).

(v) The impact of a move is greatest immediately after relocation and during the first 3 months in the new environment, but may also be evident in the period of consultation and preparation for a forthcoming move.

Action required: all relevant staff involved should be briefed on the stress/anxiety likely to be experienced by the residents and how best to help. The receiving home should be asked to identify a key worker and if possible a resident to assist the new resident to become familiar with the home.

6.0 **RECOMMENDATIONS FOR RISK MANAGEMENT: PRE-TRANSFERS**

- It should not be a 'rushed' approach. Careful, sensitive planning should be the watchword to any individual transfer. A suitable period of planning for transition should be available – this is likely to be approximately 6 months and avoiding winter months if at all possible. (However if users/relatives wish a move to take place earlier, this should be accommodated and a risk management plan identified to minimise the risks associated with a move undertaken in those circumstances.)

- Usually a maximum of 1 resident on any one day should move from the originating home between Monday and Friday. However, if groups of friends express a wish to move together and suitable staffing arrangements including travelling support can be arranged, then this should be explored as it may be beneficial to the residents for them to move and travel together. This may be a particular issue towards the end of the managed closure when the worry of being one of only a few residents left at the originating home may outweigh their concerns about transfer. In addition, if family members with to move their relative and providing suitable transfer arrangements can be made, this can be outside the maximum number transferring in a week. A risk management plan should be identified to minimise the risks associated with a move undertaken in these circumstances.

- Careful planning should demonstrate the following: adequacy of the assessment and examination of the residents in the immediate period before transfer; adequacy of the documentation; quality of transfer arrangements (particularly for residents requiring special equipment e.g. mattresses); relevant documents travelling with the resident on transfer and the need to adequately communicate care staff to care staff, nurse to nurse and doctor to doctor so that care/medical/nursing needs are fully understood by the receiving home.

- There should be flexibility and a willingness to delay a move if additional hazards are identified whilst appropriate control measures are put in place to reduce the identified risks.

- The emphasis should be on meeting the individual's needs rather than looking at the resettlement of a wider group of people as a whole. This may include a need for particular individuals to move in friendship

groups. However, individual programmes should be looked at in the context of a need to have some overall coordination.

- Visits to alternative care settings for residents and their carers should be facilitated, with appropriate transport provided where required.

- Additional staffing resources should be identified if required during the transitional period and appropriate resources identified and deployed to lead on the assessment processes, to offer additional support to the residents at the originating home. Advocacy resources should be identified where this is indicated to support individual residents.

- The residents' co-worker or nominated care worker should have oversight of the resident in the week up to their planned move. Staff should look for any changes in physical or mental well-being which may indicate a higher risk on transfer e.g. loss of appetite, onset of confusion, changes to regular toilet habits etc. If required, medical advice should be sought.

- Resident's views should be sought throughout regarding their new placement i.e. if the resident is moving to a newly constructed home/extra care unit where possible they should have involvement in decoration choices, day of transfer, staff involvement in transfer etc.

- Where supported housing/extra care is an option, social care staff should apply for relevant grants and assist in the setting up arrangements for flats/tenancies.

Table 2 – Mitigation of Risks

Risk	Mitigation
Higher levels of risk for people with dementia and confusion, particularly where there is frailty or an underlying illness	Good social care practice requires explanation, support, reassurance and more explanation. This may need to be repeated. Medical examinations on initial assessment and prior to move. Additional medical interventions if necessary at point of move. Face to face handover between medical and health practitioners if required.
Risks relating to residents requiring specific equipment, such as mattress, ceiling track host, hi-lo bath	Review of equipment needs prior to move. Equipment provision to be checked at new home before moving. What equipment can be transferred with the resident.
Risks to residents with special dietary needs and those who require support to eat or artificial feeding (such as PEG)	Support plans to be reviewed to ensure full information is included. Briefing and training of staff of receiving home by current staff. Current staff working alongside those in receiving homes if necessary short term.
Risks of impact of move through stress and anxiety over changes during preparation period and in first 3 months following move.	Full briefings on effects of stress and anxiety to all involved in supporting residents. Receiving home to allocate key worker and 'buddy' if possible to support people prior, during and following the move.
Risks of moving without adequate planning and preparation for each individual.	Planning and transition process should be scheduled for a maximum of approximately 6 months. Consideration should be given to not moving people in inclement weather. Where friendship groups are moving together, they should be moved at the same time. Focus on each individual each day for moving.

6.1 **SOCIAL AND HEALTH CARE ASSESSMENTS OF INDIVIDUAL RESIDENTS**

- An up-to-date needs-led assessment should be completed for each resident as the main way of identifying a suitable care setting/supported housing option as an alternative to the originating home. The nominated care manager should ensure that all relevant professionals, including health professionals, contribute to this. Where supported housing is an option an Occupational Therapist should contribute to the assessment process. The views of family/next of kin should also be sought. The resulting support plan should address all aspects of care, but should also include information such as dietary needs and "likes/dislikes", spiritual and/or cultural needs and other specific requirements which may be particularly important to the individual resident. As identified elsewhere in this Guidance this information should be shared with the receiving home.

- Issues relating to the safeguarding and protection of Vulnerable Adults should be referred to the host team for a Risk Assessment prior to transfer. Factors that should be taken into consideration are Capacity issues, Transfer of information to the new placement and Risk factors in relation to other residents. Therefore, guidance should be taken from the Adult Protection Team and/or Legal Services as appropriate in relation to planning the transfer.

- The completed assessment should be considered against the NHS Continuing Health Care criteria.

- Each resident should be individually assessed for their suitability to transfer and to ensure that any new provider agrees that their needs can be fully met in the receiving care home or supported housing option. A support plan should be developed jointly between the social care worker, their existing home and any new provider which should be reviewed a few days immediately before transfer to ensure that it is completely up to date.

- Incapacity - Where we are caring for an incapacitated individual, the following factors should be built into the assessment and decision making process:

- The ascertainable past and present wishes and feelings of the person concerned and the factors the person would consider if able to do so.

- The need to permit and encourage the person to participate or improve his/her ability to participate as fully as possible in anything done for and any decision affecting him or her.

- The views of other people whom it is appropriate and practical to consult about the person's wishes and feelings and what would be in his/her best interests; and

- Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less restrictive of the person's freedom of action.

- Whether there is a reasonable expectation of the person recovering capacity to make the decision in the reasonably foreseeable future.

- The need to be satisfied that the wishes of the person without capacity were not the result of undue influence.

- Where appropriate residents should have a full physical examination no more than 3 months prior to transfer, with a further examination and a medical discharge summary (dated) within 1 week of their arrival at the new home and with more assertive medical/nursing follow up (within 24 hours) for those clients who are particularly frail and/or have dementia. In the event of a medical examination being identified and not undertaken due to time restriction or referral this should be recorded and the new provider informed. The pre-transfer assessment should specifically address fitness of the resident to move and any special precautions which may need to be taken in each case (medical risk assessment).

- Clear arrangements for the medical transfer of each resident should be made prior to any relocation.

- Where applicable, a nursing transfer letter should be sent with the resident which identifies the critical issues relating to their nursing care needs. The Lead local Nurse and the relevant General Practitioners should l be involved in assisting Adult Services with this exercise, also a therapy plan as required.

- If friends or groups of friends wish to move to the same home, then where possible this should be accommodated and planned for accordingly.

- At the conclusion of this process an Operational Manager (or more senior officer) should authorise the assessment and if appropriate agree that the resident may be transferred to an available placement. They should retain oversight of the arrangements to ensure that it remained appropriate for the client to transfer and that their needs continue to be met.

6.2 ARRANGEMENTS FOR RESIDENTS TO TRANSFER

- An identified social care worker should be available for each resident and their relatives/carers to provide advice and support on vacancies, preferred area and choice of accommodation.

- Consultation should take place between the homes management team, service users and their families regarding the best way to transfer from one home to another. The management team should ensure that sufficient staff are available to support the transition. This should not normally mean more than one resident moving per day.

- No transfer should take place at the weekend – unless family or service user specifically request it and suitable arrangements can be assured. The exception should be if groups of friends express a wish to move together, relatives support the request and suitable staffing arrangements including travelling support can be arranged. This may be a particular issues towards the end of the managed closure when the worry of being one of only a few residents left as the originating home may outweigh resident's and relatives concerns about transfer.

- Following assessment including the appropriate risk assessments, the individual support plan should be reviewed and updated within 1 week prior to transfer. A formal review of each resident should be conducted at approximately 4 weeks, evaluation at 3 months and 6 months, and a 12-month review by the Social Care Worker after transfer. As is standard practice for formal reviews, all relevant parties should be invited to be involved and adjustments should be made to the support plan if required. A representative from the care home or Local Authority should visit the resident in their new accommodation within 1 month of transfer wherever feasible.

- Appropriate arrangements should be made for any new providers' staff to become familiar with the resident and their support plan prior to transfer – including familiarity with dietary and other relevant needs.

- Staff from the new residential/nursing home should be assisted to become familiar with the residents and their support plan prior to transfer.

- A visit/several visits to a prospective home, supported living environment should be arranged. Having a meal, overnight stay would

be preferable. In the case of people with a learning disability a handover over several days should be arranged. Haringey staff members should spend time with the individual resident in their new environment. This is very important as part of the settling in period.

- The Homes Manager should take responsibility for ensuring that any documentation for individual residents is fully developed and accurate, for transfer with that resident to their new accommodation.

- It should be made clear to the Registered Manager of any receiving care home or nursing home that they are empowered to refuse the transfer of a resident if they are not happy that all suitable arrangements have been put in place and that the support plans etc are absolutely clear.

- A member of the originating home's management team should contact each of the receiving homes/housing providers in the 24 hours before the date of the planned transfer of any individual as a final check to ensure they are fully prepared to accept the older person the following day.

- Ongoing contact should be maintained with the receiving home to make the transfer and this would be maintained for an appropriate period.

- Transport arrangements should be made to ensure that the vehicle is suitably equipped to accommodate the needs of the individual resident who should be accompanied by a carer who knows them and can offer support during the journey.

- Any client who is considered not to be physically well enough to move should have their transfer date put back until well enough to transfer to the new home. Appropriate medical involvement should be sought and appropriate staff involved in the assessment and treatment of the person.

- Where there is no representative/friend or family member available or on request, a care worker with the individual older person should travel with that resident from the originating home to any new accommodation in order to ensure a smooth handover to a named worker in the new unit. Negotiations should take place between the originating home and new providers to ensure that staff familiar with the residents can support

the resident who is transferred for a suitable period of time (during the first week) to ensure smooth transfer.

- The clothing, possessions and furniture of residents should go with them to the new establishment so that their new environment is as familiar as possible.

- The Manager (or identified member of the home(s) management team) on duty at the originating home on the day of transfer should have the authority to cancel or postpone the move of a resident if they have any doubts as all that it is appropriate or safe on that day. They should know that they have the support of senior managers to take this decision.

6.3 TRANSFER OF HEALTH CARE

- The residents' own GP should be asked if they have any medical advice to give concerning the transfer and where possible should be asked to continue the care of the person after the move.

- Arrangements should be initiated for a GP to be appointed at least one month prior to the transfer of any resident to a new care home/nursing home. Both the GPs at the originating home and the receiving GP should be asked to be involved in the planning of the transfer to individual residents.

- Residents should have a full physical examination no more that 3 months prior to transfer and this report should be made available to the receiving home.

- A transfer letter should be sent with the resident, identifying any critical issues relating to their nursing of care needs.

6.4 ADVOCACY

- Independent advocacy, similar to that made available during the consultation period, should continue to be offered throughout any managed closure process for residents of homes with no friends or family to assist them.

6.5 FACILITIES MANAGEMENT

Table 3 – Facilities management and actions for closure

WHAT	ACTION REQUIRED	LEAD PERSON	TIME SCALE	PROGRESS UPDATE
Gather all relevant stakeholders information	Contact/write to • Day Centres • PCT/LCC • SW/GPs • Agencies • Utilities • Community nurses • Transport • Trade directories • Neighbours			
Keys	Collect keys from any key holder			
Signage	Remove all signage			
Credit cards	Cancel all credit cards			
IT	Inform any IT department • Remove access to network • Phones to be diverted • Computers to be removed			
Insurance	• Inform building and contents insurers if building is to be empty • Liability and indemnity insurance cancelled			
Vacancy rates	Apply for vacancy rates			
Utilities	Take a reading of gas/water and electric. Ask for final phone bill and broad band bill			
Portable and electrical equipment	Remove all small electrical equipment, i.e. TVs music systems, microwaves			
Inventory	Check inventory against any checklists			
Fridges/Cupboards	Empty cupboards and fridges, leave fridge doors open			
Mail	• Inform bands and other correspondents			

	• Inform Royal Mail and have mail diverted to appropriate address			
Medicines	Remove all medicines and record disposal accordingly			
Confidential files	Remove all confidential files and archive according to current legislation			
Stationery	Remove all stationery			
Contractors	Consult services contracts. Inform contractors of termination. Serve notice if required			
Minibus/cars	Cancel insurance/contract			
Rubbish	Remove all rubbish from site/unit			
Cleaning of unit	Cleaners to action			
Petty cash	To be signed off			

6.6 FOLLOW-UP

- Personalisation and Assessment staff should complete a review 4-6 weeks after transfer, to which friends, relatives, carers and advocates should be invited to attend.

- A further evaluation should be scheduled for 3 and 6 months post-transfer.

- Following that, the usual 12 monthly (annual) review should apply, unless there is a request for a re-assessment.

7.0 DEBRIEF, FEEDBACK AND LESSONS IDENTIFIED

- It is recommended that this Guidance is formally reviewed annually but within 6 months in the first year.

- To facilitate a continuous approach to learning and improvement it is recommended that each time the Guidance is issued, the Lead Officer, following debriefings from residents, their representatives and staff should complete a learning report and make any necessary amendments to this document.

- The above to be completed within 3 months of a closure.

8.0 **CONCLUSION**

A number of factors influence the outcomes for vulnerable adults in transition from one care setting to another including the individuals' physical and mental frailty, the adequacy of social and health care assessment prior to transfer, timescales and arrangements for transfer, support systems and effective partnership, consultation and communication.

Understanding that some frail people will be particularly vulnerable to the stress of relocation, the Guidance outlined above is proposed as a way of ensuring that these issues are planned for and robustly addressed in a timely fashion. It is intended for use by lead officers to ensure the closure and transfers are handled sensitively and responsibly are employed and to provide confidence to residents, relatives and others that individuals should be treated with dignity, humanity and respect and the ongoing well-being of the individual paramount.

Appendix 1 **Other Useful Sources of Information**

Personal Social Services Research Unit: *Guidelines for the closure of care homes for older people*, October 2003.

Association of Directors of Adult Social Services*: Achieving Closure, Good practice in supporting older people during residential care closures*, Undated.

Social Care Association, *Managing Care Home Closure*, 2011.

Appendix 2 - Good Practice Checklists and Action Plans

A. Checklist for Senior Management, Registered Manager or Project Manager (Immediate Actions)

Actions	Yes/No	Named Person	Comments
1. ON ANNOUNCEMENT OF CLOSURE Have all residents and staff involved been given a written statement:			
✓ Detailing the actual facts?			
✓ Stating the reasons for the decision?			
✓ Giving any secondary decision making process?			
✓ Ensuring that the future is clear?			
✓ Ensuring that they know where they stand?			
✓ Describing the communications plan?			
2. HAS IMMEDIATE CONSULTATION WITH TRADE UNION AND PROFESSIONAL ASSOCIATIONS COMMENCED? Will these ensure:			
✓ Adequate measures for redundancy?			

✓ Or: continuity of employment?			
✓ That the staff group are retained intact for the whole of the closure and subsequent settling down period?			
✓ Full agreement with all staff on personnel issues?			
3. HAS A NAMED PERSON OUTSIDE THE HOME BEEN APPOINTED TO ACT AS AN EXTERNAL ADVISOR FOR THE RESIDENTS AND STAFF ACROSS THE WHOLE CLOSURE PERIOD?			
✓ Have they been adequately prepared and briefed?			
✓ Including the nature of their possible “contact” with the staff team and understanding of supervision as a tool?			
✓ Are they able to operate independently?			
✓ Do they have access to personal support and supervision?			

✓ Do they have access to resources, e.g. special training for staff?			
4. WILL YOU ENSURE THE INVOLVEMENT OF RESIDENTS AND STAFF IN THE PLANNING PROCESS? How will your approach to project management ensure:			
✓ Maintenance of professional standards			
✓ They have a clear sense of requirements?			
✓ Variations in user numbers over the transition period are handled professionally?			
✓ Risks are assessed and the possible harmful impact on residents is minimised?			
5. HAVE CQC, COMMISSIONERS AND OTHER LAs BEEN INFORMED OF THE CLOSURE PLANS?			
✓ Plans for closure and timescales			
Alterations required to Registration status			

✓ Commissioners notified of relevant residents			
6. HOW DO YOU PLAN TO WORK WITH RESIDENTS AND THEIR FAMILIES?			
✓ Is your key worker system effective?			
✓ Are reviews up-to-date including for self-funders?			
✓ Do you have access to advocates?			
✓ What is your approach to people with dementia?			

B. Checklist for a designated person outside the home appointed to act as an external advisor for residents and staff

Actions	Yes/No	Named Person	Comments
1. IN NEGOTIATING YOUR BRIEF WITH THE MANAGEMENT FOR THE AGENCY, HAVE YOU OBTAINED THEIR AGREEMENT ON YOUR VIEW OF:			
✓ The nature of their possible "contract" with the staff team?			
✓ Being able to operate independently?			

✓ Having access to personal support and supervision?			
✓ Access to resources, e.g. special training for staff?			
2. HAVE YOU:			
✓ Enabled residents and staff to move from a state of shock to one of being able to plan for the future?			
✓ Enabled a supportive environment and relationship?			
Agreed the "contractual parameters of working including:			
✓ Timescale?			
✓ Amount of inputs including number and duration?			
✓ Limits of authority?			

✓ The goals and basis of the sessions?			
✓ The relationship with third parties including line management?			
✓ The setting up of participative structures?			
✓ The basis of renegotiation of the “contract”?			
Enabled residents and staff to:			
✓ Ventilate their feelings?			
✓ Understand what is happening to them?			
✓ Face reality and acknowledge the changes?			
✓ Avoid resisting the change?			
✓ Face the challenge ahead?			
3. HAVE YOU:			
Enabled staff to work through and develop			

strategies to meet issues facing them			
✓ Low morale?			
✓ Limited options?			
✓ Lack of information?			
✓ Fear/anxiety?			
✓ Lack of encouragement?			
✓ Conflicting interests?			
✓ Tiredness?			
✓ Enabled the acknowledgement of satisfying experiences which can be built upon?			
✓ Fostered a spirit in which reactions staff are going through are seen as natural to the situation?			
✓ Enabled staff to look to needs beyond the stress			

of immediate problems and issues?			
✓ Enabled the establishment of a new sense of structure?			
✓ Enabled sharing within the staff team?			
✓ Fostered a spirit of working on common problems?			
✓ Enabled planning together to work upon requirements?			
✓ Fostered the creation and maintenance of positive experiences?			
Enabled the staff team to:			
✓ Obtain a sense of realism?			
✓ Be honest with each other?			
✓ Plan priorities?			

✓ Support each other			
✓ Commence realistic planning?			
✓ Think positively?			
✓ Consider options available?			
✓ Consider and work with the requirements for good practice?			
✓ Enabled any anger, resentment or complaints to be formally expressed by all?			
4. HAVE YOU: **Enabled the staff team to:**			
✓ Establish and maintain professionalism?			
✓ Look to their own and their service user's future destiny?			
✓ Maintain professional standards?			

✓ Examine factors which will/are preventing good practice?			
✓ Work through implications of any projected variation in service user numbers over the transition period?			
✓ Give guidance, advice or reassurance to residents and their relatives?			

C. Checklist for members of the care staff team

Actions	**Yes/No**	**Named Person**	**Comments**
1. IN RELATION TO COLLEAGUES, ARE YOU:			
✓ Providing a supportive environment?			
✓ Helping them to be able to adapt to change?			
✓ Helping them to retain a sense of personal worth?			
✓ Helping them to participate in establishing a new sense of structure?			

✓ Helping them to look to needs beyond the stress of immediate problems?			
✓ Examining and sharing common problems?			
✓ Planning to work through new requirements?			
✓ Discussing issues in open staff forums?			
✓ Endeavouring to create and maintain positive experiences?			
✓ Promoting a sense of realism?			
✓ Being honest?			
✓ Supporting each other?			
✓ Thinking positively?			
✓ Considering requirements for good practice?			
✓ Endeavouring to establish/maintain			

professionalism?			
✓ Examining factors which will/are preventing good practice?			
Endeavouring to minimise the damaging effect of:			
✓ Low morale?			
✓ Limited options?			
✓ Lack of information?			
✓ Fear/anxiety?			
✓ Lack of encouragement?			
✓ Conflicting interests?			
✓ Insensitivity/tiredness?			
2. AS SOON AS THE RESIDENTS ARE FIRST TOLD ABOUT A CLOSURE DECISION HAVE			

YOU ESTABLISHED:			
✓ A network of support for the service user?			
✓ Involved significant others?			
✓ Relatives?			
✓ Friends?			
✓ Field social workers?			
✓ Any others involved?			
3. 48 HOURS AFTER THE INITIAL ANNOUNCEMENT HAVE YOU:			
✓ Enabled residents to show their emotions freely?			
✓ Enabled residents to draw mutual comfort from each other?			
Discussed with relatives their fears and uncertainties about their family members' circumstances - for example:			

✓ Fears about moving?			
✓ Fears about changing key workers?			
✓ Concerns about personal finance?			
✓ Set up any sessions required for counselling residents and others?			
✓ Set up procedures/sessions for formal “reviews”?			
✓ Made provision for the continuity of care of residents?			
4. IN RELATION TO FUTURE NEEDS OF RESIDENTS HAVE YOU:			
✓ Developed a strategy to deal with any projected variation in service user numbers over the transition period?			
✓ Planned necessary group experiences and events?			
✓ Enabled residents to assess options and choices available to them e.g. by arranging visits to			

possible new establishments?			
✓ Enabled personal financial advice where required?			
✓ Enabled residents to keep in touch with any who may have already left?			
✓ Enabled residents and their relatives to talk freely to each other and to staff about their experiences?			
✓ Enabled continuity of experience for all residents?			
✓ Enabled residents to maintain contact with significant adults so as to maintain guidance or reassurance?			
COMMENTS			

Acknowledgements: ADASS, PSSRU, SCA and Sandwell Metropolitan Borough Council