# CLOSURE OF OSBORNE GROVE NURSING HOME

# GUIDE FOR RESIDENTS, CARERS AND FAMILY MEMBERS

# ASSESSMENT AND TRANSITION PROCESS

## 1. INTRODUCTION

1.1 In December 2017, Cabinet made the decision to close Osborne Grove Nursing Home (OGNH) on the grounds of sustainability of quality and safe care of residents and that the closure be managed in accordance with the Managing Care Home Closures Good Practice Guide and Management Checklist approved by the Care Quality Commission.

1.2 This document is a short guide for residents, carers and family members on the process for the re-assessment of the care and support needs of residents and the safe transition to suitable alternative accommodation. It also covers the rights of residents during the closure and transition process.

1.3 The health and the wellbeing of residents remains the primary concern of the council. OGNH will continue to be managed in line with existing processes and practices and staffing ratios will be maintained to ensure residents receive appropriate and safe care.

If there are any queries or concerns in regards to current care provision then these should continue to be raised with the OGNH management as normal.

## 2. RE-ASSESSMENT OF NEEDS AND CARE AND SUPPORT PLAN

2.1 Residents are entitled to a re-assessment of their needs and care and support plan. The assessment take into account existing care plans and risk assessment. The outcome of the re-assessments will inform the decision on the suitability of the alternative accommodation.

2.2 A Lead Social Worker from the Council and a Senior Continuing Healthcare Assessor from the Haringey Clinical Commissioning Group (CCG) will undertake the re-assessments. This will be a joint assessment. The Council will lead the assessment except in cases where the resident is eligible for continuing health care (CHC) in which case Haringey CCG will lead. The re-

assessment will be undertaken in accordance with the Care and Support Statutory Guidance (Updated February 2017).

2.3 The assessments will be residents centred and they will be supported to be involved in the process. The assessment will involve the resident and any carer or any other person the resident want to be involved.

2.4 Where residents have substantial difficulty being involved in the assessment process, the Council will look to a family member or friends who is willing, able and appropriate to facilitate the resident involvement. Where there is no family member or friend available for this role, the Council will appoint an independent advocate.

2.5 The Council has appointed independent advocates to support residents and family members to be involved in the assessment process.

2.6 Where there is concern about a resident's capacity to make a specific decision, for example because of mental impairment such as dementia, then an assessment of capacity will be undertaken in accordance with the Mental Capacity Act 2005. The Council believes that those residents who may lack capacity, may need extra support to identify and communicate their needs and make subsequent decisions, and will need an Independent Mental Capacity Advocate (IMCA). In cases where residents are assessed as lacking capacity to make specific decision relating to their care and support needs, and there are no friends or family members to represent their interest, the Council will arrange for an IMCA to be part of the decision-making process. The IMCA does not become the decision maker. However, Lead Social Worker must take account of the views of the IMCA.

2.7 The assessment meetings held for each resident will generally include the resident, family members and carers and independent advocate or IMCA.

2.9 Following the re-assessment of need and the development of the care and support plan, a copy of the draft plan will be provided to residents, family members and carers (if appropriate) and independent advocate or IMCA. They will have an opportunity to review and request amendments to the care and support plan before they are finalised. On completion, the Council will give a copy of the final needs assessment and care and support plan to the resident, any other person the resident request to receive a copy, and their independent advocate or IMCA if they have one and the resident agrees.

2.10 For residents assessed as lacking mental capacity to agree and consent to the care and support plan, the decision on the future placement will be the subject of a best interest decision meeting in accordance with the Mental Capacity Act and the Code of Practice. The resident, family members, carers, advocates or IMCA will be involved in the best interest decision meeting. In the event of a dispute as to whether the proposed care home is in the best interest of the resident, the case will be referred to the Court of Protection for a welfare decision.

2.11 The Lead Social Worker, Senior Continuing Healthcare Assessor and Independent Advocate are available for further information, conversations or meetings on the re-assessment and care and support planning process.

## 3. TRANSITION

3.1 Once the re-assessment and care and support planning process is completed, the request for new placements will be passed to the Council's Brokerage Team or Haringey CCG as appropriate. Information relating to the needs of individual residents will be shared with suitable potential homes in the borough with a view to them contacting the Brokerage Team with details of vacancies.

3.2 The details of possible vacancies will be passed to residents, family members and carers as appropriate. Visits to the prospective home can then be made as required. If residents wish to visit a potential home, OGNH Manager will arrange transport and care assistants to accompany them on a visit as appropriate.

3.3 Once a suitable placement has been agreed, the receiving Home will visit OGNH to conduct their own assessment. Residents and key staff will be included as appropriate.

3.4 In the case of a preferred placement not being available due to waiting lists, an interim placement will be found.

3.5 Brokerage will liaise as appropriate to get the new placement arrangements agreed.

## 4. TRANSFER

4.1 The OGNH Manager will oversee the preparation for transfer including organising suitable transport and a member of staff to accompany the resident.

4.2 Care staff will pack residents personal possessions and will ensure that all items are secured.

4.3 The Deputy Clinical Manager will prepare all records and medicines for transfer and the receiving Home will confirm transfer.

4.4 The Deputy Operations Manager will arrange for all appropriate equipment and personal possessions for transfer.

4.5 A follow up call will be made within 48 hours to check the resident has settled in.

4.6 A four-week review will be arranged following transfer.

4.7 We have attached below a checklist of action the Council will undertake to assist with the identifying a new home for resident and ensuring a smooth and safe transition.

**We are using a relocation checklist as devised by the Association of Directors of Adult Social Services (ADASS). This is attached in appendix 1.**

## 5. Continuity of Care

5.1 The health and the wellbeing of residents remains the primary concern of the council. OGNH will continue to be managed in line with existing processes and practices and staffing ratios will be maintained to ensure residents receive appropriate and safe care.

5.2 If there are any queries or concerns in regards to current care provision then these should continue to be raised with the OGNH management as normal.

## 6. OVERSIGHT OF THE PROCESS

6.1 The re-assessment, care and support planning and transition process to new care homes is to be overseen by a Steering Group chaired by the Director of Adult Social Services. Membership includes:

- Designated Professional for Safeguarding Adults, NHS Haringey Clinical Commissioning Group (CCG)
- Head of Service Brokerage and Quality Assurance
- Head of Adults & Safeguarding
- Transformation Project Lead (Team Leader)

6.2. The role of the Steering Group is to provide a multi-agency oversight of the process of assessment and transition, ensure that good practice guidelines are incorporated.

6.3 A Task Force Group reports into the Steering Group. Membership includes:

- Head of Adults & Safeguarding
- Interim Home Manager
- Quality Assurance Nurse Manager – Care Homes, NHS Haringey Clinical Commissioning Group (CCG)
- Deputy Clinical Manager
- Lead Social Worker
- Commissioning and Safeguarding Officer
- Transformation Project Lead (Team Leader)

6.4 The Task Force Group is responsible for the operational delivery and management of the assessment and transition process and that good practice guidelines are followed.

## 7. RESIDENT RIGHTS

The process set out above embeds the rights of residents. These are summarised below.

7.1 Residents have the right to a re-assessment of their needs and care and support plan.

7.2 Residents have the right to be involved in the re-assessment and care and support planning process.

7.3 Where residents have substantial difficulty in being involved in the re-assessment and care planning process, they have the right to support by friends and family members (if appropriate), by an independent advocate or by an IMCA where they lack mental capacity.

7.4 Residents have the right to a copy of the completed needs assessment and care and support plan, and request that copies to be made available to friends, family members, independent advocate or IMCA.

7.5 Where there are concerns that a resident may lack capacity to make a particular decision, the resident is entitled to a mental capacity assessment that is compliant with the Mental Capacity Act 2005 and Code of Practice.

7.6 Where residents are assessed as lacking capacity to make a decision about their placement, residents are entitled to a best interest decision meeting that is compliant with the Mental Capacity Act 2005 and Code of Practice.

7.7 Where there are disputes about whether the proposed placement is in the best interest of the resident, the case can be referred to the Court of Protection for a best interest welfare decision.

7.8 Where residents are deprived of their liberty as part of their care and support plan, it must be authorised by law.

7.9 Where residents are dissatisfied with the manner in which their case has been managed, they can make a complaint to the Local Authority complaints department via the Feedback and Information Governance Team at 020 8489 1988 or email FIG@haringey.gov.uk.

If they are unsatisfied with the response, they can also make a complaint to the Local Government Ombudsman.

In the case of continuing healthcare funded residents, complaints can also be made to the CCG department. Visit http://www.haringeyccg.nhs.uk/pals-and-complaints.htm

7.10 Where residents believe that the council has acted unlawfully in re-assessment and/or care and support planning process, they can seek a judicial review of the assessment and care plan.