PROCEDURES FOR MANAGING THE CLOSURE OF A CARE HOME PROVIDING SERVICES FOR ADULTS

Nursing Home Closure Policy V9 May 2012

See also: Barrow Modernisation – Home Closure Principles and Protocol
Purpose and Aims
These procedures and guidance are to be followed when notification is received that a registered care home is going to close. The procedures set out a professional and sensitive way of managing the transfer of residents from a residential or nursing home and the subsequent closure of that home.

Reasons for closure of a registered care home include:

- Actions taken by receivers or creditors which prevent the care home from operating
- Cancellation of the care home’s CQC Registration
- Termination of the contract without reason subject to a minimum period of 3 months notice (12 months for NHS contracts)
- Termination of the contract forthwith due to a fundamental breach

The final two points above may not in all cases result in the closure of the home, as the provider may still operate but not under our contract. In these cases removal of residents funded through our contract will need to be arranged and measures should also be taken to inform other residents and their family/friends of the reasons for the cease of contract so that they can make an informed decision as to whether they wish to remain or not.

The paramount consideration should be to ensure that customers needs continue to be met with the least disruption and stress to them. The actions required are not necessarily sequential nor are the procedures intended to restrict staff from using their initiative and responding sensitively and imaginatively to unforeseen situations or to particular individual needs.

Transferring from a familiar setting, either as an individual or as part of a group, is likely to be stressful, however good the new surroundings. Groups of residents who have lived alongside each other for a long time may be separated. For a frail older person such a move can be a threat to their physical, psychological and social well being. It is very important therefore to be aware of the risks, to handle the process sensitively and to be prepared to delay or halt a transfer if necessary. The impact of a move is probably greatest in the period after the move itself, but simply to know that a change is planned is in itself a stressful experience so sensitive preparation is needed.

Clearly there will be limited preparation time where there is to be an immediate cessation of trading, but every effort should be made to ensure that any moves are undertaken with sensitivity to the individual needs of the residents and actions should be taken in consultation with any relevant relatives, friends, advocates or others (e.g. Health) who may be required to or willing to assist residents to seek alternative placements. In the case of a planned closure, best practice must always be followed.

Where there are safeguarding issues these need to take precedence and locally agreed safeguarding vulnerable adults procedures/policies should be followed.
Roles and Responsibilities

Upon notification to the Local Authority that a care home is to close, the designated District Lead for the area in which the home is situated must be notified and they will take on the Co-ordinator role for developing and implementing the plan of action.

Local authorities are required to safeguard the needs and welfare of all residents in care homes in their area, regardless of whether they are self or publicly funded and regardless of which local authority has placed them there.

The District Lead:

- Will identify key stakeholders to include a Clinical Co-ordination Lead if appropriate (see below) and form project group as appropriate and develop a plan of action.
- Will allocate an Operational Manager responsible for allocations to undertake an assessment/review of each resident.
- Will liaise with all members of the project team to co-ordinate activities and help to resolve any issues arising.
- Appendix 5 – Template for recording relevant contact details for all those involved in the action plan (with suggested entries, to amend/add to as required).
- Will develop a communication plan with all parties agreeing a policy on information sharing between themselves and what to communicate more widely.

Contracts and Commissioning:

- Will nominate a key contact within the contracts and/or commissioning teams of each of the commissioning organisation(s) who is familiar with the home to assist with communication with the home and contractual issues.
- Where commissioning responsibilities are shared between Local Authority and NHS commissioning organisations, the contracts and commissioning teams will liaise to decide who will take the lead for aspects of the process.
- Contracts teams will provide advice on processes and requirements of the contracts of each commissioning organisation and liaise to ensure the requirements of all relevant contracts are met.
- In the case of planned closures due to financial insolvency, the Contracts team and the relevant budget holder will work with the Home's management to ensure that there are no reasonable available options to avoid closure.
- Commissioners can help to maintain continuity of care in a home threatened by market failure in a number of ways, for example by:
  - Discussion of different pricing options
  - Retaining the existing contract, but providing financial assistance in the form of a grant or a loan
  - Seconding staff to the care home on a temporary basis.
- There is no automatic right for a commissioning organisation to put its own staff into a home; only if this is by agreement or already in the terms of the contract.

(NHS Contractual Context & Responsibilities see Appendix 7)
Care Navigators:

- Will identify availability of alternative placements once notified of the relevant registration requirements, via the care homes vacancy list.

The Home Manager:

- Will identify a lead member of staff within the home to work with the project team. This key contact will be responsible for supplying information on residents to assist with determining need for assessment and assistance with finding an alternative placement.

Health:

- If the home provides nursing care or continuing health care health will identify a key person to liaise with staff undertaking assessments to advise on the residents' medical conditions and/or health related needs.
- GP's should be consulted regarding any concerns about a resident's health needs.
- Incident Supervisor to work with GPs and keep them fully informed of process and progress.

The Relevant Manager:

- Will, in liaison with the home, identify those residents who will require assessment/review and assistance in obtaining alternative placements.
- Liaise with any other Local Authorities/PCTs/NHS Commissioners who may be funding any of the residents within the home
- Consult and work through any issues with relatives, staff and other departments and agencies in an open and helpful way.
- Liaise with ASC/Health Commissioners Finance regarding changes in individual agreements.

Assessment staff will:

- Assess/review the needs of each individual resident in accordance with guidance on Fair Access to Care Services.
- NHS staff to contribute to Nursing care or lead the process if fully funded NHS Continuing Health Care. This process will also include those individuals who are self-funding who can also refuse and choose to make their own arrangements.
- Consult with the relatives, friends, advocates and other relevant persons involved with each resident and take their needs/views into account.
- If the person has no representative, consider a referral to Advocacy services
- If appropriate, consult with the resident's GP as to their health needs and any medical risks that may arise from the proposed transfer.
- In liaison with the key worker from the home, draw up individual support plans
- Organise and implement transfers
- Monitor the impact of transfer on residents, relatives and carers

Customer Service Centre

- The District Lead should ensure that staff dealing with the public are aware of the situation so that they can respond appropriately to any enquiries from concerned people.
Communications

- The District Lead should ensure that Senior Managers and the Communications team are aware of the situation so that they can respond appropriately to any media communications.
- A list of Frequently Asked Questions should be devised early on in the process as a way of reducing the number of individual queries that have to be answered.

Care Quality Commission (CQC)

- Information needs to be shared with CQC throughout the process, particularly about the maintenance of standards of quality and safety during the closure and future plans for residents.

Best Practice

Minimizing 'transfer trauma' necessitates an ongoing piece of work involving the whole system around the individual concerned. This includes for example friends, family, care staff, professionals and companions in the home. The residents need to be allowed to have a voice and given as much control over events as possible in what is a very disempowering and anxiety provoking situation. In most cases any meaningful control over events will be negligible. Consequently those involved need to be given proper opportunities to articulate their feelings about their situation and to make sense of what is happening. Various interventions such as advocacy, counselling, group work, even the offer of transport to keep in contact with former companions, could have a therapeutic value to individuals and could go some way to giving them a sense of involvement.¹

The following are some areas of best practice to be considered when dealing with the closure of a care home, however the ability to follow some of the best practice guidelines will be affected by the timescales within which the home is to be closed. For example in the case of 'immediate' or 'urgent' closures, there will not be time to undertake many of the tasks, however, the main principles should be followed wherever possible; clear communication, consultation, enabling the resident to have as much control as possible and supporting people to adapt to change by considering their needs as individuals. In the case of a planned closure, best practice should always be followed.

- Importance of placing customers needs and wishes at the heart of care plans and consulting properly with service users and their families/carers.
- Maintaining continuity of care and relationships with staff wherever possible.
- Involving existing staff as far as possible under the presenting circumstances will do much to allay anxiety in residents.
- Moving staff and residents together (to minimise disruption). Wherever possible residents should not be separated from long term friends and/or staff.
- Paying particular attention to the needs of people with cognitive impairments.
- Providing adequate support for care managers (who may experience complex and stressful demands)
- Consultation and discussion to improve people's sense of autonomy.

¹ Scourfield, P (2004) Questions raised for local authorities when old people are evicted from their care homes, British Journal of Social Work, 34(4), 501-516
• Visits to new accommodation before transfer
• Allowing the maximum possible time to select a new home
• Emphasising potentially positive outcomes
• Trying to reduce the amount of environmental change (moving people to physically similar places or services with a similar atmosphere)
• Where providers require additional staff to cover an increase in placements they should give consideration to employing staff from the closing home as this would offer residents some continuity.
• Allocating a key worker to be responsible for each person’s care (with scope to visit the person in their old home, get to know them, talk to staff and greet the resident as they arrive in their new home).
• Moving as much as possible of residents’ familiar furniture with them
• Providing particular support on the transfer day itself (for example, with familiar staff, family and close friends accompanying the person, a key worker to greet the person as they arrive, new staff knowledgeable in advance of the person’s routines, encouraging residents to unpack themselves or seeing where everything is put and encouraging residents to talk about how they are feeling)
• Robust care planning and communication to support people’s preferred lifestyles in the new home
• Care planning and goal setting for care staff to help residents adjust (including spending as much time as possible with a new resident).
• Care managers should contact relatives and identify what support they need
• Standards of care and staffing levels should be maintained in the home that is closing, familiar routines should continue and existing staff should be employed throughout the closure period where possible.
• Attention to information governance and protection/secure transfer of personal information between providers including ensuring disposal of computerised and paper records as necessary.

Assessments of Individual Residents
The relevant Local Manager/s will allocate a social worker to undertake the individual assessment of each resident. Where the person is funded through NHS continuing health care resources, the relevant health community will need to take the lead on assessing the patients who are fully funded by NHS funds or who are self-funding NHS patients.

The assessor will seek advice from the resident’s GP as to the health needs of the person and the medical risks if any from the proposed transfer. If the GP so advises, an appropriate consultant would be requested by the GP to supply an opinion. This advice will form part of the assessment.

The assessor will arrange for an advocate to be provided to assist the resident participate in the assessment when appropriate.

The assessment will identify the needs of the resident and their relatives or carers and allow for the drawing up of a care plan. The assessment will be conducted in accordance with guidance on Fair Access to Care Services.
Some individuals are more susceptible to the impact of relocation than others. They are likely to be more affected by any life event. Characteristics which identify people likely to encounter the greatest difficulty include:

- Evidence of previous breakdown in response to stress
- Age, with very advanced age making it more difficult to adapt
- Gender – men by and large adapt less well to change and stress than women
- The presence of pathological impairments which may produce physical impairments, reduced mobility or urinary incontinence and/or make it more difficult to understand the environment (e.g. reduced eyesight, reduced hearing or deafness or other loss of sensory facility)
- The presence of depression, anxiety or a demonstrated vulnerability to such symptomology is likely to be exacerbated by any move
- The presence of cognitive impairments, such as impairment of the facility to understand, comprehend, remember and reason with the information that a move is to be made makes the individual particularly vulnerable. No matter how much effort is put into explaining the situation and to help them come to terms with it, all that work may be lost because of the failure to register and remember. In addition to this, fragments of an understanding and the anxieties associated with that understanding or half understanding may come back repeatedly to haunt the individual.

Combinations of these vulnerability factors increase the risk of adverse reactions to the relocation stress and their presence should be noted.

**Procedures**

The actions required are not necessarily sequential. The accompanying checklists set out what the project team and all those involved, have to have done to deliver this process satisfactorily. A checklist for Area Operations Managers/District Leads dealing with 'immediate' home closures is attached at Appendix 3, along with a suggested list of contents for an Emergency pack, Appendix 4, which all home should have available in the event of home closure.

- **Action on Notification**
- **Arranging Assessment/Review**
- **Undertaking Assessment/Review**
- **Identifying alternative provision**
- **Arrangements for Transfer**
- **Transfer and Follow up**

**Action on Notification**

1. The District Lead will identify a Local Teams Manager to organise the assessment of the individual residents within the establishment.
2. The home will identify a member of staff who will act as co-ordinator for the home.
3. For planned closures, where time allows, a meeting should be held in the home for all residents, relatives or friends, to explain what is planned, introduce those responsible for the process and explain their role and indicate the timetable for the closure. If this is not possible, then
individual meetings should be held with each resident with their family/friends to give this information.

4. The home will provide a list of all residents affected by the closure/contract termination (see Appendix 1 for suggested template), including who is responsible for funding, the name of the GP, and name of the key representative for each person. Information should also be given as to whether the person is currently in a dementia unit, or in a dual registered home due to an impending need for dementia unit care.

5. For each of the residents a list of key contacts should be drawn up (see Appendix 2 for suggested template), giving name and contact details and what their role is. This should include family, friends, GP, any professionals involved (e.g. District Nurse, CPN, etc.) and including information to indicate if any of the contacts have Appointeeship, Power of Attorney or solicitor in terms of Court of Protection.

6. The home that is closing should ensure that each resident has a list of their property, in preparation for the imminent move.

7. The District Lead/Health Commissioners will make a request to the Contracting Teams for a list of care homes with the relevant registration category who have current vacancies. The District Lead will agree how frequently they require updates of this information dependent on the timescale of the closure (as this information will change frequently).

**Arranging Assessment/Review**

8. If any of the residents are funded by other Local Authorities, the Home Manager will contact that authority to advise them of the situation, including advice for them to contact the appropriate Local Authority if they wish us to assess/review the person on their behalf, giving the number of the District Lead as a contact. If assessing on their behalf, close communication will be needed to co-ordinate the transfer.

9. Where residents are self funding or funded privately by relatives, the Local manager will make enquiries to identify what assistance they need in the arrangement of alternative accommodation. For some this will be in the form of providing lists of homes with vacancies that they can contact (if they wish to make the arrangements themselves), but for others it may require an assessment to be undertaken in order to offer full support to enable the person to find an alternative placement and undertake the transfer. Support to self funders should always be offered.

10. In all cases, contact should be made with all residents and/or relatives/friends, to explain the situation and establish what level of support is required. Agreement should be reached with the resident as to the degree that family, friends or carers will be involved in identifying an alternative home and associated arrangements. All assessments should be undertaken with the involvement of the resident and any relevant relatives/friends.

11. If the person has no relatives or friends to support them, then consideration should be given as to whether they would benefit from the involvement of an advocate, and if so a referral should be made.

12. If the person lacks capacity and has no appropriate representative then a referral must be made to an IMCA for a Best Interests Assessment to be undertaken in regard to any decisions being made. If there is any evidence of a potential deprivation of liberty then advice should be sought from the DoLS team as to whether an application should be made. See [Mental Capacity Implementation Policy & Procedures](#)
13. The allocated worker will undertake an assessment of each individual resident and a care plan should be drawn up in liaison with the resident, their family/relatives/friends and the current care home key worker. If the resident is funded by another Local Authority, this should be done in consultation with a worker from the funding authority.

14. The assessment and care plan should summarise the residents' personal history, likes and dislikes and the patterns of care provided so far. Special needs including cultural and spiritual needs as well as physical needs, such as special equipment (e.g. hoist, bath aids, continence supplies, etc.) or chiropody services should be identified. If any particular pharmacy supplies (such as oxygen) will be needed, then the community pharmacist should be informed.

15. The plan should include the individual's preference for diet, eating habits, bathing and toileting arrangements, and any idiosyncrasies which staff at the receiving care home should know about.

16. If the person has a degree of hearing impairment, it is important to ensure that hearing aids are maintained and batteries are available. For those with a visual impairment anything that can be done to make the layout of the new surroundings similar to what they have been used to will help. They will need time and help to get used to a new layout.

17. The needs of relatives or carers to be able to visit or contact the resident in the new home should be taken into account and if necessary action should be taken to explore the possibilities.

18. A risk assessment should be undertaken to identify any potential risks which may arise if the person is moved, involving health professionals if appropriate. A risk management plan should be developed and any serious risks should be notified to the Local Manager who will notify the District Lead. The District Lead will liaise with the project team to discuss timing and method of transfer for these residents, including investigating the option of postponing the closure until such risks can be effectively managed or minimised.

19. Consideration should be give at all times as to the person's capacity to agree to any move and whether any arrangements made may constitute a deprivation of liberty.

20. Staff should look out for any residents who become withdrawn, depressed or anxious about the move and ensure this is notified to the assessment team.

**Identifying alternative provision**

21. The resident's consent to transfer of information and records should be obtained and recorded.

22. The outcome of the assessment and the care plan identifying the options of where care could be provided should be recorded and communicated to all relevant persons involved in the individual's care. Options for future care should also consider the potential alternative forms of support other than residential care (e.g. extra care sheltered housing, home care packages, direct payments, etc.)

23. In consultation with the individual, relatives/friends and any professionals involved, the preferred choice of alternative home should be identified, using the list of vacancies provided whilst ensuring that the preferred home can offer suitable accommodation and has the appropriate registration category. Residents and/or their representatives should be made aware of any 3rd party contribution required by homes, as this may affect their decision and is required to ensure that they are making an informed choice.

24. When identifying preferred choice, consideration should be given to groups of residents wanting to move together wherever possible.
25. The assessing worker will contact the preferred home to establish that there is a vacancy available, and make any necessary arrangements to establish that it is a viable move. Wherever possible this should include the resident and/or relatives being able to visit the home and for home staff to meet with them to establish suitability. However, it is acknowledged that this would not be possible in the event of an "immediate" closure, so as much information as possible should be provided to the resident and to the chosen home, to enable that decision to be made.

   a. Where the number of people requesting a particular home exceeds the number of places, there will need to be a robust and defensible allocation process in place to manage competing priorities.
   b. Where a person's first choice is not immediately available, interim placements can be offered - though choice elsewhere may be constrained by availability and the willingness of a new provider to accept the placing authority's terms and conditions
   c. The needs of groups with protected characteristics must be addressed - i.e. age, ethnicity, religion, disability, mental capacity, sexuality.

Arrangements for Transfer

26. The date and time that the transfer will be made will be agreed between the new home, the resident and/or family/friends and the closing home. These arrangements should be communicated to both residents and relatives/friends in writing. Staff involved in the transfer in both settings should also get information in writing.

27. Once a decision has been made, and the home is agreeable to accepting the resident, the assessing worker will complete the relevant documentation with the proposed date of moving, which will be sent to the Local Manager for approval. The documentation should include details of any 3rd Party contribution if applicable. The assessing worker must also ensure that the existing agreement with the current home is ceased with effect of the date of moving.

28. The District Lead, in liaison with the Local Manager will oversee the arrangements for transfer for the group as a whole, taking individual preferences into account whilst ensuring the fair allocation of vacancies. This may involve negotiation with other authorities or with privately funding residents/relatives where more people are choosing one home than that home has vacancies for.

29. Once funding is approved, arrangements should be made to facilitate the transfer according to the individual's needs. This should include, but is not an exhaustive list:
   - Medical or clinical arrangements, e.g. do they need to change GP
   - Transport arrangements for the resident and who will accompany them, including times, destinations and type of vehicle required. (See Appendix 6 for range of transport options to be considered)
   - Pharmacy and medication arrangements
   - Equipment, aids and other supplies
   - Arrangements for dealing with the residents' personal finances
   - Arrangements for packing and moving personal possessions (these should preferably be carried in suitcase or suitable bag, not in plastic bag or waste sack).
   - Arrangements for leaving the home (e.g. opportunity to say goodbyes) and for meeting and greeting at the new home (by someone they are familiar with wherever possible).
• Notification to any other relevant parties about the move, for example relatives who have not been able to be involved in the move, GP, District Nurses, DSS, etc.

30. Staff from both homes, together with the assessing worker, will draw up and follow a checklist for each person detailing tasks and actions to be undertaken, identifying responsible staff and the times by which each of the tasks or actions should be completed. The key workers in both settings should agree and co-ordinate the completion of the checklist, which will be checked by the assessing worker.

31. At any stage, those identified as responsible for tasks or actions should inform the assessing worker if they have any concerns about the transfer arrangements or the appropriateness of the agreed timetable. These concerns should be recorded and held with the residents care plan. If they are not resolved then the resident and their relatives/friends should be informed and a review meeting held.

Transfer and Follow up

32. On the day of the transfer communication should be maintained between the assessor, the closing home and the new home, to co-ordinate and confirm departures/arrivals and handover of properties.

33. Following transfer, a formal review should be held after four weeks, involving the assessor, key worker and the resident, to identify if the care plan is meeting existing or new needs. All interested parties should be invited to be involved. Further reviews should be planned according to the outcome of this review (e.g. there may need to be a review held three months later, or it may be decided that it can wait for the annual review).
## Appendix 1 - List of Residents

<table>
<thead>
<tr>
<th>Name of Home to be closed</th>
<th>Number of Residents</th>
<th>Anticipated date of Closure</th>
<th>Date of notification of closure</th>
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<tr>
<th>Name of Registered Home Manager</th>
<th>Name of Key Contact</th>
<th>Registration category of home</th>
<th>Is this a registered nursing home? Yes/No</th>
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### List of All Current Residents

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Responsibility for funding</th>
<th>Customer number (if known)</th>
<th>GP Name</th>
<th>Dementia Unit Required</th>
<th>Main representative</th>
<th>List of key contacts attached? Y/N</th>
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# Appendix 2 - Residents Contact List

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Title</th>
<th>Relationship</th>
<th>Address</th>
<th>Telephone number</th>
<th>Additional Information</th>
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Appendix 3 - Checklist for Managing Care Home Closures

This is meant as a joint Health and Adult & Community Services Aide Memoir for use in the event of a Care Home closing. Each authority will have its own Legal responsibilities and procedures to perform, and this aide memoir must be used in conjunction with these.

The following checklist focuses on "immediate" cessation of trading; however they are also applicable to all of the situations where a home is closing for any reason.

It is not suggested that the actions below are sequential:

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Authority</th>
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<tbody>
<tr>
<td>Have all relevant personnel been notified of the action which is taking place and where necessary mobilised</td>
<td>District Lead</td>
</tr>
<tr>
<td>Have the procedures for relocating residents been discussed with the proprietors</td>
<td>District Lead</td>
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<td>Has all staff in the home been advised of the situation and has their help with the move been requested</td>
<td>Home Manager</td>
</tr>
<tr>
<td>Have the residents been advised of what is happening</td>
<td>Home Manager</td>
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<tr>
<td>Has the bed vacancy situation been established</td>
<td>District Lead</td>
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<tr>
<td>Has an up to date list been obtained which shows each resident's full name, their next of kin, their GP and who is financially responsible for their placement</td>
<td>Home Manager</td>
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<tr>
<td>Has information been collated about residents next of kin, and who are subject to Court of Protection arrangements or have appointee agreements for pensions</td>
<td>Home Manager</td>
</tr>
<tr>
<td>Have relatives and friends been contacted to explain the position and the options available (NB if they are not immediately available, it will be necessary to keep trying).</td>
<td>Home Manager/Local Manager</td>
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<td>Where appropriate have independent Advocacy services been contacted</td>
<td>Local Manager</td>
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<tr>
<td>Have people who are responsible for finding alternative placements been provided with relevant information</td>
<td>Local Manager</td>
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<tr>
<td>Where necessary have assessments been carried out involving all appropriate professionals</td>
<td>Local Manager</td>
</tr>
<tr>
<td>Has resident's personal property been packed</td>
<td>Home Manager</td>
</tr>
<tr>
<td>Have each resident's records/care plans, drug sheets, pension books, money and valuables been placed in a sealable envelope to accompany the resident to the next placement</td>
<td>Home Manager</td>
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<tr>
<td>Have the details of the new placement of each resident been properly recorded</td>
<td>Assessment Staff</td>
</tr>
<tr>
<td>Have all checks been made that the chosen placement will accept the person, at an agreed time and date</td>
<td>Assessment Staff</td>
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<tr>
<td>Has transport been arranged and full information been given about the destination to facilitate smooth transfer arrangements</td>
<td>Assessment Staff</td>
</tr>
<tr>
<td>Have all Senior Managers/media team been informed</td>
<td>District Lead</td>
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Has a record been made of the departure of each resident and of their destination | Home Manager/Local Manager
---|---
Have relevant Health and Adult & Community Services Offices (including on call facilities) been given a list of the destination of residents | Local Manager
Has the registration certificate been removed from the home and a receipt issued (if applicable) | Contracts
Have patient and other records been transferred securely and computerised records deleted securely ? | Contracts/Information Governance/IT

If the home is a nursing home, or if the resident is physically or mentally incapacitated the following may be appropriate:

| Ensure that the resident can be identified personally (e.g. by an identification wrist band) | Home Manager
| Contact resident’s GPs for advice on moving individual residents | Local Manager
| Contact the on-call Consultant Physician, Hospital Administrator and Ambulance Service to keep them updated. | Local Manager

In the days following the closure, the following actions may be necessary:

| Complete the notification process | Assessment Staff/Local Manager
| Make follow up visits to residents | Assessment Staff
| Contact the relatives about any property left in the home | Home Manager
| Notify DWP and others that the home has closed | Home Manager/Local Manager
| Write letters thanking people for their co-operation and assistance | Home Manager
Appendix 4 - Emergency Pack for a Care Home Closure

An 'Emergency Pack' for use in the event of the 'immediate' closure of a home should include:

- Copy of this Procedures document
- Resident identification and property sheets
- Choice of destination record sheets
- Resident identification wrist bands (only to be used where the resident is too confused or too ill to identify him/herself)
- Plastic property bags (for use when no suitcases are available)
- Identification labels for luggage
- Sealable plastic bags for drugs
# Appendix 5 - Contact Details for Project Team

<table>
<thead>
<tr>
<th>Service</th>
<th>Lead Person</th>
<th>Service Contact Number</th>
<th>Service Out of hours number</th>
<th>Email</th>
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Appendix 6 – Transport Options

Possible options for transport are:

- Resident's Family
- Health (patient transfer service, ambulance, etc)
- Local providers (taxi, etc)
- Emergency Transport Provision
Appendix 7 – Contractual Arrangements

Contractual context

Local Authorities and NHS organisations are generally required by their Financial Regulations to set up formal legal contracts with organisations they purchase services from. NHS commissioning organisations purchasing services from care homes are required by the Department of Health to use the current NHS Standard Contract for Care Home Services. The standard NHS contract was introduced to provide a framework to hold providers to account for the delivery of high quality services to NHS funded service users. The contract formalises the legal and financial purchasing arrangements and gives support to commissioners in the process of managing quality and performance issues, including both incentives for improvement and disincentives for failure.

The NHS Standard Contract for Care Home Services makes provision for termination of a contract in various circumstances, including termination by the Provider, termination by the Commissioner, and termination where a home is closing. In these circumstances specific clauses will apply requiring the provider to cooperate with commissioners and any new providers to ensure a smooth transition and minimise risks and “inconvenience” to services users. There are also clauses covering payment, and a clause which applies specifically when termination happens with immediate effect, requiring the provider to implement its Business Continuity Plan and ensure there is no interruption of service. Clauses about service user information, confidentiality and data protection among others survive termination.

Contractual responsibilities

The contracts Cumbria County Council and NHS Commissioners holds with care homes both set out processes for managing performance issues including suspension and termination of contracts, arrangements for individual service user agreements and formal notices to providers. Reference should be made to the contracts when concerns first start, and initial notices sent to providers if required, to enable sanctions or measures to be taken if necessary at a later date. Where a home is closing, there will be contractual implications and requirements, and may be financial considerations. Both NHS and County Council commissioners and contracts teams should work together throughout the process, referring to their respective contracts for relevant action and serving notices where necessary, either jointly or separately as their contracts require.