

The Provision of Equipment in Care Homes

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The Provision of Equipment in Care Homes

Executive summary

Purpose and Background

This paper is designed to promote understanding between managers of care homes and community equipment services and other parties interested in the provision of equipment in care homes. As such, it will point the way for the development of local policies and agreements.

Definitions

Definitions of some of the terms used, such as 'fit for purpose' and 'standard and non-standard community equipment' are provided in Section 3 and Annex B.

Principles

Equipment provision should be focused on client need and provided by the care home if it is the type of equipment usually required by its clients. Equipment provided must be safe and staff properly trained. Equipment services may provide some equipment for the temporary use of an individual when the need falls outside of the home's general provision. Loaned equipment should be properly maintained and returned promptly.

Assessment

There are different levels of assessment, ranging from self assessment, to initial, advanced and complex (perhaps multidisciplinary) assessments. The latter three need to be undertaken by appropriately competent people.

Risk Management

Care homes have responsibilities to clients and staff and some equipment carries particular risks of which homes need to be aware. Equipment risks need to be managed in the context of advice from the Medical Health products Regulatory Agency (MHRA).

Working in partnership

There are some situations where local agreements are essential and organisations responsible for commissioning community equipment

services (which may be PCTs, local councils, or both in the case of integrated services) must ensure that clear policies and auditable procedures are in place. These are particularly necessary so that disputes do not arise when a client's condition or situation changes.

There are areas where care homes and community equipment services can productively collaborate:

Community equipment services should be willing, subject to local agreements, to help care homes with:

- Advice on equipment.
- Staff training for equipment use and management.
- Equipment hire and loans.
- Maintenance and decontamination.

Care homes should be willing, subject to local agreements, to help community equipment services by:

- Identifying when equipment is no longer required and returning it promptly.
- Informing the service promptly in the event of equipment breakdown.
- Notifying changes in clients for whom equipment has been loaned.

The Provision of Equipment in Care Homes

1 Purpose of the paper

The purpose of this paper is to:

- Clarify the relationship between community equipment services and care homes. (Section 7.3)
- Provide a shared language to improve understanding. (Section 3 and Annex B)
- Provide a basis for local protocols and contracts. (Section 7)
- Enable lead commissioners of integrated community equipment services to identify their obligations in relation to care homes for adults and older people. (i.e. the paper excludes equipment for children and 18 or 19 year olds in full time education.) (Section 7)
- Help care home owners understand their obligations to clients.
- Identify relevant Department of Health guidance. (Annex A)
- Clarify the assessment process, in particular distinguishing between assessment for equipment and assessment for funded nursing care. (Section 5)

2 Background

Equipment/medical device provision in care homes is a national issue affecting end users and frontline staff.

A care home is defined as a local authority, NHS, private residential home or care home with nursing that is licensed by the National Care Standards Agency to provide services under the Care Standards Act 2000. (See Annex A: References)

Care homes provide a range of care including intermediate care, transitional care, palliative care and continuing care. (See Annex B: Definitions)

Many types of equipment can be expected to be provided in care homes and they should relate to the care for which the homes are registered.

There are significant differences in funding, definition and equity between areas.

People in local authority and private care homes have the same rights to services, including the provision of equipment, as those living in their own homes.

3 Definition of terms used in this document

Community equipment services (CES): Local health and council services (which may be contracted out) that provide community equipment on loan under provisions of various legislation relating to the NHS, councils, community care, and children. Equipment is provided to people of all ages to help them perform essential activities of daily living and to maintain their health and autonomy and to live as full a life as possible.

Community settings: End users' own homes and care homes registered under the Care Standards Act, but exclude private hospitals registered as care homes.

End users: 'Patients', 'clients', 'service users' and informal and funded carers in community settings.

Equipment: Various known as 'medical devices', 'community equipment', 'assistive technology'. The Department of Health *Guide to Integrating Community Equipment Services* (2001) elaborates the description of equipment.

Fit for purpose: There are a number of requirements for care homes to support the clients that they take under contract or as self-funders. The provision of standard and non-standard equipment is one such requirement. (See Annex B: Definitions)

Special authorisation rules: Individual equipment services will have local policies that set out who is competent and authorised to prescribe standard or non-standard items.

Standard community equipment: Equipment widely available to end users in their own homes. Standard equipment may:

- Be used by more than one person.
- Be frequently/regularly used by the end user.
- Support care given by informal or funded carers.
- Supporting general personal or nursing care
- Assist activities of daily living and enable independence.
- Be issued without the requirement for an advanced assessment.
- Be for short term or long term need.
- Support a safe environment for users.
- Be subject to local policy authorisation under the CES policies.

Non-standard community equipment. This may differ from standard equipment by being:

- Uniquely prescribed for an individual.

- Frequently or infrequently used by the end user.
- A specific solution to a particular incapacity, long term disability or medical/nursing problem.
- Prescribed by an individual who has received enhanced training.
- Needing enhanced training to operate and clinically use, or to teach others to operate it.
- Supplied by the CES under special authorisation rules or may not be part of the standard equipment service.
- Non-standard equipment is divided into one of the following three categories:
 - Category 1: Equipment purchased 'off the shelf' for an individual. Could be used without further adaptation by others but is subject to special authorisation rules.
 - Category 2: Bespoke equipment. Designed or adapted or bio-engineered and manufactured for a specific individual.
 - Category 3: Specialist equipment for which there is specific Department of Health provision under EL(95)5 regulation, etc. These are usually provided on prescription by medical staff, e.g. PEG nutritional feeding, continuous ambulatory peritoneal dialysis (CAPD), intravenous chemotherapy for cancer people. NB in many places Category 3 equipment is not provided via the community equipment service.

4 Principles for provision of equipment in care homes

4.1 Overriding principles

The purpose of providing the equipment is to increase or maintain functional independence of end users (including funded and informal carers), or to allow for their safe management within the care home.

Cases are assessed on their individual need, e.g. very tall or bariatric (obese) persons. However, the equipment needs of people residing in care homes are not necessarily the same as clients residing in their own homes, as there is access to professionally managed twenty-four hour care. Recognised and agreed assessment tools must be used in all assessments.

Consideration must be given to the most cost-effective method of addressing the assessed need.

Staff must be appropriately trained in the use of the equipment as set out in the Medical Health products Regulatory Agency (MHRA — was the MDA) MDA DB 9801 and other related documents.

Training in the clinical use of the equipment is the responsibility of the prescriber or delegated other and written instruction must be provided.

Equipment passed from one user to another must be cleaned and/or decontaminated as determined by the national standards on decontamination, manufacturers' instructions and local community equipment service guidelines.

<http://www.medical-devices.gov.uk/mda/mdawebsitev2.nsf/webvwOtherPublications/AAAADF24915B412280256C8B003EE71F?OPEN>

4.2 Self-funding clients

The principles contained in this paper should apply to everyone regardless of their financial status.

4.3 Care home standards and equipment

Minimum standards for care homes for younger adults and national minimum standards for adult placements identify that a plan of care, which includes all requirements for an individual, must be implemented.

The Minimum Standards for Younger Adults set out what is expected of the individual care home.

- Standard 6 (service users plan)
- Standard 17
- Standard 25
- Standard 29 (provision of environmental adaptations and disability equipment)

Similarly, the Minimum Standards for the Older Person set out:

- Standard 6 intermediate care
- Standard 7 for a plan of care
- Standard 8 tissue viability prevention and management
- Standards 22 for specialist equipment
- Standard 38 (safe Working Practices)

Care homes that are contracted to take local authority clients for social care, people with learning disabilities and other disabled people and/or contracted to provide health care (accommodation, personal care, and funded nursing care), are expected to make provision for the standard equipment to fill their obligations to those clients and to their work force. This provision could be through purchase by the home, for example, or through a hire/maintenance arrangement with an equipment service.

4.4 Who should provide the equipment

The starting point on 'Who should be providing what?' is that to meet national care standards, care homes should be 'fit for purpose'.

Therefore, any care home must have an adequate supply of equipment/medical devices to meet the 24 hour needs of their clients (Care Standards Act 2002 Statement of Purpose (4) (13:1b and 5) (Service Users plan (15;1) (Part IV Premises)

HSC 2003/006:LAC (2003)7 *Guidance on NHS Funded Nursing Care* Paragraph 30 says:

It is expected that care homes providing nursing care will be fit for purpose, which, in the main, means they will have in place basic handling, mobility, and lifting equipment and adaptations. There may be some situations where they will need to draw on the resources of the local community equipment service. Both health and local authority services have received additional funding from April 2001 to integrate and enhance these services. Where the NHS has determined that an individual requires a particular piece of equipment, it should ensure either that the care home provides it or that it is provided on a temporary basis as long as the individual requires it or until the care home is able to provide it.

For care homes providing nursing care, equipment is highly likely to include, amongst other things, equipment such as pressure reducing and relieving overlays and replacement mattresses to maintain tissue viability (static and dynamic systems). That is, if a client in a care home providing nursing care is assessed as requiring preventive care for pressure ulcers, the care home should provide for that client.

When a person is being considered for a place, assessment of their needs should include consideration of the equipment that is needed to support their care.

Care homes should not accept people whose assessed needs they are unable to meet. However, where the absence of a particular piece of equipment in a care home is *temporary* and the provision of equipment would facilitate a discharge from an acute hospital bed, or enable the client to stay in the home, the local community equipment service should step in.

In particular, where an individual has a need for equipment which is either bespoke or out of the ordinary, and where the equipment could not be used for another client when the need has passed, the care home will wish to obtain a temporary loan from the local community equipment service.

Appendix C contains an example of a matrix setting out an agreement for who provides what which is used by one equipment service and its local care homes. If adopted in other localities, it should be adapted according to local circumstances.

4.5 Equipment loaned to a care home

Equipment loaned by a community equipment service will be for the exclusive use of the person for whom it was prescribed. If other people use the equipment and an incident occurs, the provider cannot be held liable.

The loan of equipment to nursing homes is non-discriminatory, in line with legislation, policies and guidance. Ethnic and cultural aspects of the household must be taken into account. It may be necessary to seek appropriate advice.

The community equipment services provider must give technical instruction to the nominated care home personnel and end user. Thereafter it is the responsibility of the nominated care home personnel to cascade the instruction to any other people who require it.

Day-to-day operational cleaning/disinfection is the responsibility of the care home and must follow manufacturers' instructions and local guidelines.

The care home will meet the cost of all repairs arising from negligence, damage or inappropriate use and the cost of replacement if it is lost.

All repair and maintenance of CES provided equipment would be co-ordinated and carried out by the community equipment service staff or nominated other.

Care home staff will be responsible for notifying the community equipment service when the individual no longer requires a loaned item of equipment and will make arrangements for its return. They will also be responsible for informing community equipment services when equipment breaks down or requires repair or service, and will make it accessible when needed.

5 Assessment and assessors

5.1 General points

- Assessment identifies need and the outcome determines care solutions, which could be advice and may include the provision of standard/non-standard equipment.
- Equipment prescription by health professionals can be identified as part of a single assessment process, in the case of older people or for younger people part of other care pathways.
- All staff assessing for equipment must be competent and confident, having received appropriate training.
- First level assessment is carried out by a suitably trained person who is working to what is 'reasonably' expected of someone of the grade at which they are employed.
- Advanced assessment is carried out by a professional who has received enhanced training and is employed to carry out that type of assessment.
- Single assessment process: Assessment, proportionate in scale and depth to the care needs of older people, with the elimination of duplication between agencies. (See Annex B: Definitions)
- Assessment for funded nursing care: Conducted to determine nursing needs that will be funded by the state. (See Annex B: Definitions)

5.2 Self assessment

People in care homes should be able to access local self assessment processes if they wish.

5.3 Initial assessment

This may be carried out by suitably trained care professional/s for any person in a care home, or before being admitted to it. If equipment is identified as a way of meeting a particular need, and this prescription is beyond the competencies of the practitioner involved, then an advanced or complex assessment should be undertaken.

5.4 Advanced assessment

Where, as a result of the initial assessment, the suitably trained care professional has identified that assessment by a professional with enhanced skills is required. By its nature, an advanced assessment is likely to result in the prescription of either a non-standard or bespoke piece of equipment.

5.5 Complex assessment

A complex assessment depends on the nature, complexity, intensity and unpredictability of the person's condition. A multi disciplinary assessment may be required.

6 Risk management

6.1 Range of issues

Standard 38 of the National Minimum Standards implies that the care home manager must ensure, 'so far as reasonably practicable, the health, safety and welfare of residents and staff. The registering manager will be expected to comply with relevant legislation, ensure that safe working practices are in operation, and provide a written statement of the policy, organisation and arrangements for the maintenance of safe working practices.' (Cooper 2002). This covers matters such as:

- Skin integrity/tissue viability.
- Health and safety risk assessment.
- Manual handling.
- Fire safety.
- First aid.
- Food hygiene.
- Infection control.
- Near miss, incident, and accident reporting.

6.2 Skin integrity/tissue viability

If, as part of the assessment (and using the agreed local risk assessment tool), the end user is identified as at risk of developing pressure injuries, the care plan must include the provision of equipment to prevent and/or treat these injuries and it must be reviewed regularly.

6.3 Health and safety

The provision of certain types of equipment (for lifting and handling, for example) can be important for care homes as employers in relation to their health and safety responsibilities. 'Employers are required to define the preventative and protective measures to be taken in respect of any identified risks'. *Management of Health and Safety at Work* (HSE 1999). The legislation identifies five main employer obligations:

- To assess the risk to the health and safety of staff and anyone affected by work activity.
- To make arrangements for putting into practice the preventative and protective measures that follow from the risk assessment.
- To set up emergency procedures.

- To inform and train staff as necessary.
- To carry out health surveillance of employees where appropriate.

NB: All medical devices management (including the staff training), is covered by *Equipped to Care: the safe use of medical devices in the 21st century* and *Devices in Practice: a guide for health and social care professionals* published by the MHRA in 2000 and 2001 respectively. (See Annex A: References) [http://www.medical-devices.gov.uk/mda/mdawebsitev2.nsf/c049cb2907fee7ea00256a7600410668/faf7e41862cae98700256ad8003c80e9/\\$FILE/Equipped-to-Care.pdf](http://www.medical-devices.gov.uk/mda/mdawebsitev2.nsf/c049cb2907fee7ea00256a7600410668/faf7e41862cae98700256ad8003c80e9/$FILE/Equipped-to-Care.pdf)

6.4 Management of medical devices

All equipment/medical devices used to support the care of clients and patients is required to be managed and maintained as required in the guidance by the Medical Health products Regulatory Agency (MHRA) MDA DB 9801, and its subsequent guidance.

Each PCT now has an MHRA liaison officer and that person should be the first port of call for local advice. www.mhra.gov.uk Tel: 020 7273 0000 (weekdays 9-5).

7 Working in partnership

There are some situations where local agreements are essential and organisations responsible for commissioning community equipment services (which may be PCTs, local councils, or both in the case of integrated services) must ensure that clear policies and auditable procedures are in place in relation to care homes. These will cover a number of topics including:

- Equipment funding.
- Eligibility criteria.
- Borders and out of area placements.
- Appropriately structured assessments.
- Users' changing conditions and re-assessment to ensure that equipment is still needed and used.
- Conformity to national targets, such as equipment delivery times.
- Collaboration between care homes and the community equipment service.
- Dispute resolution.
- Ensuring, through the care standards registration function, that new care homes opening in the area are made aware of the local policies on equipment provision.

7.1 Borders and out of area clients

To provide seamless care, neighbouring services should aim to standardise service and equipment delivery across professional, geographical and cultural boundaries.

There are many practical difficulties because the various organisations involved in commissioning have different boundaries. There is no one right way of handling these matters. Wherever borders are drawn, clarity on who is responsible for what is important. Strategic health authorities, with their broad perspective, could be asked to broker agreements if necessary.

There is elaboration of the issues of geographical borders on the ICES Team website, www.icesdoh.org/article.asp?Topic=77

7.2 When a user's condition or situation changes

The following points may be used as a starting point for developing local pathways for provision.

It is against the ethos of care to move end users from their present settings if their new condition is short term. In these cases community equipment services may be expected to provide equipment on loan. Examples of such changes of condition are:

- A client in a non-nursing care facility deteriorates and may not survive. (Palliative care*)
- A client in a non-nursing facility may have to receive acute care with an identified rehabilitation (intermediate care*) period.
- An individual needs treatment for pressure ulcers after discharge from hospital and is a new or current resident of the care home.
- The end user deteriorates and needs additional long term care (continuing care*) and requires equipment over and above the local standard equipment provision.
- The end user requires standard equipment in non-standard sizes or to support bariatric requirements.

See Annex B for definitions.

The care home would be expected to provide equipment in the situation where a client who is registered as a certain band in social care or health care and the banding changes permanently as the result of banding adjustment owing to further deterioration.

7.3 Collaboration between care homes and community equipment services

Community equipment services should be willing, subject to local agreements, to help care homes with:

- Advice on equipment.
- Staff training for equipment use and management.
- Equipment hire and loans.
- Maintenance and decontamination.

Care homes should be willing, subject to local agreements, to help community equipment services by:

- Identifying when equipment is no longer required and returning it promptly.
- Informing the service promptly in the event of equipment breakdown.
- Notifying changes in clients for whom equipment has been loaned.

Annex A: References

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Annex B: Definitions

Care Home

From Care Standards Act 2000. Care home defined in Chapter 14

3. - (1) For the purposes of this Act, an establishment is a care home if it provides accommodation, together with nursing or personal care, for any of the following persons.

(2) They are-

- (a) persons who are or have been ill;
- (b) persons who have or have had a mental disorder;
- (c) persons who are disabled or infirm;
- (d) persons who are or have been dependent on alcohol or drugs.

(3) But an establishment is not a care home if it is-

- (a) a hospital;
- (b) an independent clinic; or
- (c) a children's home,

or if it is of a description excepted by regulations.

Fit for purpose

From National Minimum Standards document page ix.

- ♦ Fitness for purpose. The regulatory powers provided by the CSA are designed to ensure that care home managers, staff and premises are 'fit for their purpose'. In applying the standards, regulators will look for evidence that a home – whether providing a long-term placement, short-term rehabilitation, nursing care or specialist service – is successful in achieving its stated aims and objectives.
- ♦ Meeting assessed needs. In applying the standards, inspectors will look for evidence that care homes meet assessed needs of service users and that individuals' changing needs continue to be met. The assessment and service user plan carried out in the care home should be based on the care management individual care plan and determination of registered nursing input (where relevant) produced by local social services and NHS staff where they are purchasing the service. The needs of privately funded service users should be assessed by the care home prior to offering a place.

Single Assessment Process

From NSF for Older People chapter 2.27

- <http://www.doh.gov.uk/scg/sap/> - Key Implications, Guidance for Local Implementation and Annexes to the Guidance.
- The purpose of the single assessment process is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively. In pursuit of these aims, the single assessment process should ensure that the scale and depth of assessment is kept in proportion to older people's needs; agencies do not duplicate each other's assessments; and professionals contribute to assessments in the most effective way.

Nursing care

From HSC 2001/17: LAC (2001)26 Appendix 1

"services provided by a registered nurse and involving either the provision of care or the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse" (Section 49 of the Health and Social Care Act 2001).

Palliative Care

(From Palliative Care policy lead, Department of Health)

Specialist palliative care is the active care of patients with progressive disease (often far advanced) and limited prognosis, and their families, by a multi-disciplinary team who have undergone specialist training. It may be provided by a range of NHS and voluntary providers that specialise in palliative care who together contribute to an integrated specialist palliative care service for a given population

Intermediate Care

(From HSC 2001/01 : LAC(2001)1)

7. ...intermediate care should be regarded as describing services that meet all the following criteria:
 - a. are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care;
 - b. are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
 - c. have a planned outcome of maximising independence and typically enabling patient/users to resume living at home;
 - d. are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less; and
 - e. involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

8. Based on current practice, an intermediate care episode should typically last no more than six weeks. Many episodes will be much shorter than this, for example 1-2 weeks following acute treatment for pneumonia, or 2-3 weeks following treatment for hip fracture. Exceptionally, for example following a stroke, patients may require intermediate care for slightly longer than six weeks. Nevertheless, all individual care plans for people receiving intermediate care should include a review date within the six-week period. Exceptional extensions beyond six weeks should be subject to a full re-assessment and should be authorised by a senior clinician. Individual care plans should specifically address what care, therapy or support may be needed on discharge from intermediate care.

Continuing Care

From HSC 2001/015: LAC (2001)18.

"The care which people need over an extended period of time as the result of disability, accident or illness to address both physical and mental health needs. It may require services from the NHS and/or social care. It can be provided in a range of settings, from an NHS hospital to a nursing home or residential home and peoples own homes."

Annex C: Undergoing revision from 8 December 2003 to 31 January 2004

This annex is undergoing revision at this stage. The new matrix (available from February 2004) will not be based on an existing example as before, it will be a list of equipment types that can be used in developing local agreements. Local organisations will be able to make all of their own entries into the matrix.