COVID19 Care Home Support > Implementation Status

Local Authority: Sefton

Total number of CQC registered care homes in your area: 131

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Please submit local plans (covering letter and this template) to **CareandReform2@communities.gov.uk** by **29 May**

Complete

**Please enter the number of registered Care Homes in your local area, where the corresponding action or support is in place*

Key COVID19 Support Actions for Care Homes	*Number of Care Homes (Please see note above)	Would additional support be helpful to progress implementation further? (Yes/No) *If Yes, please offer a brief description of the type of support that would be helpful*		Please indicate any issues that you would like to highlight (optional)
Focus 1: Infection prevention and control measures				
1.1) Ability to isolate residents within their own care homes	107	No	Advice and guidance given to Care Homes best practice models shared through provider forum model. Commissioning of additional care homes beds, encompassing enhance primary and community services for Covid positive patients and "step-down" beds to support 14 day isolation of patients before returning to homes where needed.	
1.2) Actions to restrict staff movement between care homes	93	Yes	Advice and guidance given. Provision of mobile phones to enable GP and community services remote video consultation through AccuRx and Attend Anywhere applications.	Best practice model advice needed and evaluation of most cost effective models would be welcomed.
1.3) Paying staff full wages while isolating following a positive test	30	Yes	Financial support model availible to help Care Homes meet the cost of additional staffing. Further engagement with the market needed.	Please note 76 said no and 25 didn't respond
Section complete				
Focus 2: Testing				
2.1) Registration on the government's testing portal	88	Yes	Advice given to all homes and reiterated through communications and engagement on Prioritisation roll out, further support to be continued through the Outbreak Cell	
2.2) Access to COVID 19 test kits for all residents and asymptomatic staff	40	Yes	Process established. Prioritisation model to be finalised. Support on response plans if the results reflect high positive status in staff need. We are aware that care homes have encountered a range of problems when trying to access the national whole home testing portal. We are also aware that some homes are excluded from this problem as they are not registered as caring for older people or people with dementia. We are working locally to address this system inequality.	Clarity of routes inclusive of all Care Homes types
2.3) Testing of all residents discharged from hospital to care homes	80	No	Fully implemented and confident we are compliant with a flexible block contract method to manage (JK)	
Section complete				
Focus 3: Personal Protective Equipment (PPE) and Clinical Equipment				
3.1) Access to sufficient PPE to meet needs	107	No	Good levels of PPE in homes. Continued support to maintain. Levels fluctuate still work to do in terms of supply chain and we continue to hold emergency supply in the council and CCG. Assurance over the quality of PPE has been raised.	
3.2) Access to medical equipment needed for Covid19	79	No	Full audit of current situation in relation availability of thermometers. pulse oximeters and BP monitors and level of training completed. Additional pulse oximeters distributed through NHSE scheme and procurement of additional equipment being progressed.	
Section complete				
Focus 4: Workforce support				
4.1) Access to training in the use of PPE from clinical or Public Health teams	94	No	Train the trainer super used model being rolled out . Training and Trainer" programme. Involving range of partners including local CCG, Council, Community services and care home volunteers	
4.2) Access to training on use of key medical equipment needed for COVID19	64	No	Systematic training programme underway as part of the " Training and Trainer" programme. Involving range of partners including local CCG, Council, Community services and care home volunteers	
4.3) Access to additional capacity including from locally coordinated returning healthcare professionals or volunteers	64	Yes	Local lead to act as point of co-ordination identified but further work do be done to identify local need	Support to understand collation of this and process to allocate to homes.
Section complete				
Focus 5: Clinical support				
5.1) Named Clinical Lead in place for support and guidance	86	No	In South Sefton, community matron and PCN leads have been identified in all care homes for the elderly. Each of our Care Homes has an identified clinical leadto offer support and guidance. Each care home has a named Medicines management team lead enabling co-ordinated implementation of a wide ranges of support covering homely remedies supply, fast track supply and support for administration and reuse of end of life medications, review of medications on discharge from hospital and support with monthly supply of medicines. Local Primary Care Networks (PCNs), community service providers and specialist support from secondary care providers, have made good progress to meet the following key requirements :- • Delivery of a consistent weekly 'check in', to review patients identified as a clinically priority for assessment of care. • Development and delivery of personalised care and support plans for care home residents • Provision of pharmacy and medication support to care homes Many of our care homes now have all three elements in place, with work underway to ensure full coverage as soon as possible. Community nursing colleagues are playing a key role in facilitating the weekly check-ins and identifying patients who are in need of proactive support such as those who have been discharged from hospital, recent admissions to a care home or those who have a change in condition. Multi-disciplinary Team Meetings (MDTs) involving a range of health and care professional are established, where clinically appropriate, in some cases involving specialist geriatric services. Our personalised care planning process is already in place and being implemented and our medicines management support is being supplemented to move to deliver standardised medication reviews in all homes on a routine basis.	
5.2) Access to mutual aid offer (primary and community health support)	104	No	In addition to the support listed above, there is an agreed escalation policy in place for if and when a care home experiences difficulties, which is under constant revision. AGP FIT testing good example of utilisation of Mutual Aid model where local community trusts offered urgent support for local care homes where needed.	
Section complete				