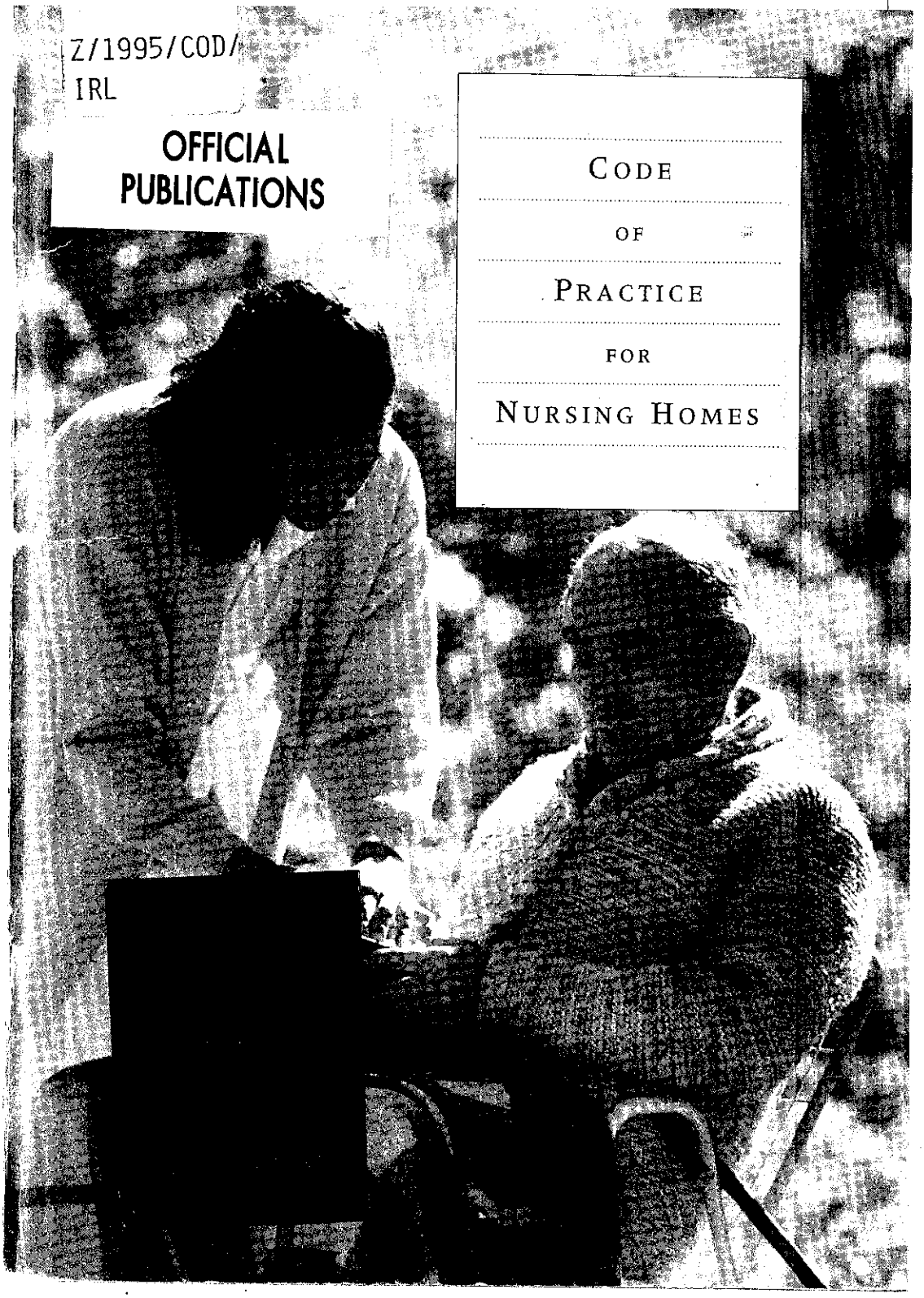
CODE OF PRACTICE FOR NURSING HOMES



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FOREWORD

BY THE MINISTER FOR HEALTH

As Minister for Health, I am committed to providing a caring and efficient health service for all in our community and in particular for the growing number of dependent elderly people, who are amongst the most vulnerable groups in our society.

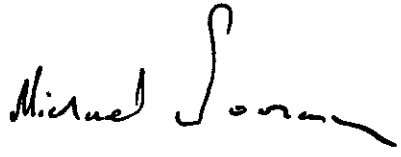
The Health (Nursing Homes) Act, 1990 which came into effect on 1st September, 1993 has two principal objectives. Firstly, it aims to ensure that all nursing homes which care for the dependent elderly of the country have a high standard of accommodation and care. Secondly, it provides financial assistance to dependent persons who need nursing home care and who cannot afford to pay nursing home fees.

Legislation by its nature, is concerned with minimum standards. Those involved with the care of dependent elderly have felt the need for a code of practice which would set out the best standards of care to which all nursing homes should operate. This Code of Practice for Nursing Homes was drafted by a group of experts with first hand experience of caring for the dependent elderly.

This Code is intended to help nursing home proprietors and staff, officers of health boards and the general public to a better understanding of what constitutes high quality care in nursing homes.

While the Code of Practice is primarily intended for nursing homes, it is hoped that it will have an important influence on care in all long-stay hospitals and homes.

This Code of Practice for Nursing Homes has been prepared by experts in the care of the dependent elderly. I have no doubt that it will influence for the better the standards of care of residents in nursing homes.



Michael Noonan TD

Minister for Health

July, 1995

1 INTRODUCTION

1.1 The Report of the Working party on Services for the Elderly - ***The Years Ahead - A Policy for the Elderly*** (October 1988) recognised the long tradition of nursing homes in offering extended care to dependent elderly persons. The Report recommended that the law governing nursing homes be updated. The Government accepted this recommendation and new requirements for nursing homes are contained in the Health (Nursing Homes) Act, 1990. The Nursing Homes (Care and Welfare) Regulations, 1993 set out the detailed standards of care and accommodation which must be provided in all homes. The Act and the Regulations apply to all private and voluntary nursing homes.

1.2 Nursing homes cater for an increasing number of elderly people. They are an important element in the overall provision of health care for the elderly. Nursing homes offer residential nursing and personal care for dependent people. Nursing and personal care includes help with washing, bathing, dressing; assistance with toilet needs and the administration of medicine. Good care in a nursing home respects the privacy, autonomy and individuality of residents and promotes choice and flexibility. A nursing home must also ensure that the medical needs of residents are met and that any therapeutic regime recommended by a doctor is carried out.

1.3 The Health (Nursing Homes) Act, 1990 and the Nursing Home Regulations which came into effect on

the 1st September, 1993 represent a strengthening of the legislation on standards and care for residents of nursing homes. The main aim of the new legislation is to ensure that high standards of care and accommodation are provided in nursing homes. Health boards will continue to support elderly people at home where possible, thereby preventing unnecessary admission to residential care. When admission to extended care becomes necessary, the provisions of the new legislation should ensure that the elderly person and their relatives can have complete confidence in the standards of care in private and voluntary homes. The new legislation respects the rights of persons to seek care in a nursing home of their choice.

1.4 Legislation governing standards in nursing homes is necessary because of the vulnerability of the residents of nursing homes. Minimum standards are set by the Act and the Regulations. This Code should encourage nursing home owners and staff to go beyond these minimum standards and achieve the highest possible standards. The National Council for the Elderly and The Report of the Working Party on Services for the Elderly, ***The Years Ahead - A Policy for the Elderly*** recommended such a Code to promote uniformly high standards of care. The aim of the Code of Practice is to promote a good quality of life for residents in nursing homes. The Code does not prescribe a single approach but it aims to foster good practice and indicates desirable norms.

1.5 The Code is intended to help nursing home proprietors and staff of health boards and the general public to a better understanding of what is involved in providing care of a high quality to residents of nursing homes. It is hoped that the Code will encourage a sense of partnership between those responsible for providing care in homes and those whose duty it is to see that high standards and good practice prevail.

1.6 This document has been agreed by a group of people representing proprietors of nursing homes, health boards, the National Council for the Elderly, carers and other people with experience in the care of the elderly. It represents a consensus of what constitutes good nursing home care at the present time. Nothing in this document should be construed as interpreting or qualifying any statutory provision or regulation.

1.7 'Person responsible' in the context of this document means the person most involved in the care arrangements for the elderly person. It may be the next of kin, a close friend or in certain circumstances, the health board.

2 PHILOSOPHY OF CARE

2.1 A good nursing home provides a high standard of care and treatment to dependent people who can no longer live at home, in accommodation and in an environment which replicates home life as closely as possible. Such a nursing home creates an environment that seeks to develop, maintain and maximise the full potential of each resident. The philosophy of care should be to promote the greatest possible independence of each resident.

2.2 Residents should live in comfortable, clean and safe surroundings. They should be treated with respect. Staff should be sensitive to their individual needs and abilities. The management of the home should be flexible and promote individual care. Staff should be trained to recognise and develop individual abilities to the maximum extent. Residents should enjoy a lifestyle that is as non-institutionalised as possible. The quality of life, as well as the quality of care, is shaped to a large extent by the attitudes of staff at all levels in a home.

2.3 The residents in a nursing home put themselves into the care of other people but their rights as individuals must continue to be respected.

2.4 The particular needs of people in nursing homes will, to a large extent, be determined by their degree of dependency. It is important that the organisation of a home and the attitude of staff reflect the need for

residents to achieve and maintain maximum independence. This will demand sensitive handling by staff and adjustments as the residents' needs change. The care of patients with dementia poses particular problems for staff. Special liaison will be required between the home and health board community and specialist services.

2.5 The preservation of the residents' dignity is important. The opinion and preferences of residents must be treated with respect. Recognition of talents, sensitivities and beliefs should be an essential feature of the way staff respond to residents.

2.6 For some residents communal life in the home will create its own problems. Residents should be encouraged to respond to the needs of other residents and to respect their rights.

2.7 Residents should be able to exercise choice in many aspects of daily life. They should not be regimented or subject to rigid routines. Residents should be allowed reasonable individuality in matters such as clothing, food preferences, bed times, meal times and throughout the usual daily activities. Staff should be aware of, and provide for, religious and cultural observances, both dietary and ritual. As well as providing an environment which encourages individuality and self-awareness, the staff of homes should encourage the self-confidence and motivation in those with the capacity to live more independently.

2.8 Not all residents have a permanent need for residential care but some may become conditioned into comfortable dependence. Where possible residents who recover sufficient independence should be encouraged to return home or move to sheltered accommodation. It is easy to underestimate the qualities, experiences and talents of people in residential care and in so doing to lower their morale. Staff should be aware of the individual's identity and their past achievements. The residents should be encouraged to keep up their links outside the home. This will give them access to alternative supports and other sources of advice.

2.9 The quality of life in a nursing home will be enhanced by the availability of a wide range of normal activities. For those who are able to do so opportunities to go shopping, attend places of worship, visit the cinema, theatre, clubs, pubs and so on should be available. For the more dependent residents opportunities for social interaction should be encouraged to the limit of the person's ability. Re-orientation and reminiscence therapy are a valuable way of encouraging this interaction. Residents should have the opportunity to express and pursue religious and political beliefs. This may involve recognition of practices such as prayer and contemplation which require privacy and quietness.

2.10 Residents should be encouraged to mix together at meal times, in the day rooms and during organised activities.

2.11 Responsible risk taking should be regarded as normal and residents should not be discouraged from undertaking certain activities solely on the grounds that there is an element of risk. Excessive paternalism and concern with safety may lead to infringements of personal rights. Those who are competent to judge the risk to themselves should be free to make their own decisions as long as they do not threaten the safety of others.

3 INTRODUCTORY VISITS

3.1 A registered proprietor should encourage prospective residents who are capable of doing so to visit the home so that an informed personal decision can be made about entering the home. Similarly, it is also desirable that a member of the staff of the home should visit the prospective resident at his or her present accommodation so as to establish a personal relationship, gain information about the way of life and advise on possessions which can be accommodated in his or her room. Such a visit must also be acceptable to the prospective resident.

4 TRIAL STAY

4.1 The first two months of a resident's stay in a home should be considered as a trial period. This period should allow time for the resident or his or her relatives to decide if the home is suitable and for the person in charge to decide whether the home can offer the person the right kind of service. It is therefore advisable for a registered proprietor to ensure that the resident or the person responsible for his or her care, will make alternative arrangements if the placement proves unsuitable. The person responsible should be made aware of the nature of the trial period. Similarly, residents coming from their own homes should be advised not to take any irrevocable step, such as selling a house or terminating a tenancy, until they are certain that they want to stay. During the trial period a resident or the person responsible should be given a copy of the draft contract of care to be agreed between the proprietor, the resident and/or the person responsible.

4.2 At the end of the trial period the registered proprietor should discuss fully with the prospective resident and person responsible the suitability of placement. Decisions about future care arrangements should be recorded and implemented.

5 CONTRACTS OF CARE

5.1 Under Article 7 of the Nursing Homes (Care and Welfare) Regulations, 1993 a written contract of care must be agreed between the registered proprietor, the prospective resident and/or the person responsible within two months of admission to a nursing home. The contract should cover:

- The services to be provided for the resident.
- The level of fees, time and method of payment, whether in advance or arrears.
- Extra services and appliances which are charged separately. These services should not include any service listed in Article 16.2 of the Nursing Homes (Subvention) Regulations, 1993 if the resident is in receipt of a subvention from a health board.
- A procedure for increasing fees when this is necessary.
- Provision for a review of placement.
- The personal items which the patient may bring to the home and those which the home will be expected to provide.
- Arrangements for the care of pets, where pets are allowed.
- The terms under which the resident can vacate accommodation temporarily, whether for holidays or admission to hospital.
- The circumstances in which the resident might be asked to leave.

- Procedure on either side for terminating the agreement or giving notice of changes.
- Statement of insurance cover of the home and responsibility for insuring personal valuables. The level of cover for residents' property, if provided, should be made clear and details of insurance given.
- Provision for the observance of religious beliefs of the resident.
- Procedure on the death of a resident taking into account the known wishes of the resident.
- Arrangements for holidays away from the home.

6 GENERAL REVIEWS

6.1 A comprehensive nursing review of each resident should be undertaken by the nursing home at least once every six months. This review should be independent of any review which may be undertaken by a health board of a resident in receipt of subvention, although the two reviews may be linked. A nursing review should cover the general health and social functioning of a resident, and should be regarded as an opportunity to extend methods of rehabilitation and prepare residents for leaving if this is appropriate. A record of the review should be kept with the resident's notes. The resident and person responsible should normally be amongst those involved in such reviews.

7 HEALTH SERVICES

7.1 Admission to a home should not diminish a person's access to the health and welfare services available in the community and in acute hospitals. This includes the right to choose a general practitioner, consultation in private at any time and consultation on the independent request of the general practitioner. Residents are also entitled to receive good quality assessment, treatment and rehabilitation in acute hospitals. Residents for whom the health board is responsible should receive a comparable range and level of service to that which they would receive if they were at home or in a health board home or hospital.

7.2 The Nursing Homes Regulations facilitate arrangements between the registered proprietor and the health board in relation to the provision of services such as physiotherapy, occupational therapy and chiropody. These should be developed according to the needs in different areas.

8 DOMESTIC ROUTINES

8.1 Domestic routines are necessary for the smooth running of a home, but they need to take into account both individual needs and preferences and the desirability of a lifestyle which is as normal as possible, especially in relation to bathing, getting up, access to rooms, going to bed and meal times. Routines should be applied in a friendly, understanding way and offer maximum possible choice, dignity and privacy to patients. Meal times should coincide with the normal time of family meals. Staff should ensure that night checks, while effective, do not invade privacy unnecessarily and are carried out in a sensitive manner.

8.2 Residents should be given the greatest freedom possible consistent with their state of health, the convenience of other residents and the operation of the home. Rules relating to residents should be kept to a minimum and employed only to promote rehabilitation, fulfil statutory requirements, prevent undue disturbance to other residents or ensure reasonable standards of safety and hygiene. As far as possible these rules should be written down. Behaviour which endangers or seriously inconveniences others should be distinguished from behaviour which involves only the individual concerned. The latter, such as bathing unassisted or going out unaccompanied, should be restricted only if the resident is not capable of making an informed decision or if it runs counter to a therapeutic regime.

9 INVOLVEMENT OF RESIDENTS IN DECISION MAKING

9.1 Residents should be involved as much as possible in making decisions concerning the routines of a home which affect them. Decisions about smoking areas will be important to some people. Menu planning and choice of food, should involve residents. In particular, social or other activities should not be forced upon residents and should not be introduced without consultation. Involvement will, however, depend on the ability and interest of residents. It would be good practice for homes to have procedures for consulting residents and acting on their views. Residents or their representatives should have reasonable access to the registered proprietor or person in charge to express their views when they wish to do so.

10 MODES OF ADDRESS

10.1 The way elderly people are addressed and the use of names is important. It is important to take account of individual preference in the way names are used. A person is entitled to be called what he or she wishes, whether it is Mrs Murphy, Eileen Murphy or Eileen. A name is not simply a means of identification. It is a personal possession to be handled in the manner its owner chooses. Moreover, it is reasonable to wish to be addressed in different ways by different people. A resident may be on first name terms with fellow residents but expect staff to use a surname and title.

11 MEDICATION

11.1 The Guidelines for the Administration of Medical Preparations for Nursing/Midwives of An Bord Altranais oblige each nursing home to have a written policy and procedures for nurses on the administration of medical preparations. The policy and procedures must conform with the statutory obligations of the Misuse of Drugs Act, 1977-1984 and the Medical Preparations (Prescription and Control of Supply) Regulations, 1993 and with the contents of the Guidelines of An Bord. Nursing management in the home must be involved in the formulation of the policy and procedures.

12 RESTRAINT

12.1 Restraint is the use of physical or chemical means to control the movement of a resident. Restraint should only be used to prevent injury to the resident or to other residents. The use of catheters, buxton chairs, cot sides and some drugs may have the effect of restraining a resident and their use should be carefully considered.

12.2 Every home should have a policy on the use of restraint, based on the guidelines of this Code of Practice. The use of restraint on an on-going basis should never be the decision of one person. The use of physical or chemical restraint should be kept to a minimum. Where the nurse in charge of a home considers that a person may need to be restrained, he or she should first consult the resident's general practitioner. The person responsible for the resident as well as the registered proprietor should also be informed. A record of all occasions on which physical or chemical restraint is used should be kept, detailing the nature of the restraint and the duration. The use of restraint should also be noted in the resident's nursing notes. There should be a regular review of policy on restraint in the home.

13 RESIDENTS' ACCESS TO PERSONAL RECORDS

13.1 People have a right to know what is said about them in records maintained about them. It is good practice for staff of a nursing home to share information with residents in the context of an open and professional relationship. Residents who wish to have access to written records should be enabled to do so. In some instances, sensitive information may need to be disclosed in a discreet way. The responsible person should have access to these records with the consent of the resident. Where the resident is in receipt of a subvention from a health board, a designated officer of the board who is a medical practitioner may inspect the resident's medical record.

13.2 The following safeguards should be respected:

- information about a third party should not be disclosed to a resident without the consent of that third party;
- information derived in confidence from a third party should not be disclosed without the consent of the third party;
- in exceptional circumstances it may be concluded after the most careful assessment that, for example, a resident's instability or lack of insight is such that he or she would need to be protected from the disclosure of matters which have for him or her a special and damaging significance;

- in wholly exceptional circumstances the longer-term interests of the resident may require his or her protection from confidential judgements made and recorded by members of staff. The responsible person should be informed of such circumstances.

13.3 Any decisions to withhold requested information should be taken only by the registered proprietor or the person in charge. In such a case, the resident may appeal to the health board and the registered proprietor or person in charge should be able to explain the reason for the decision to the satisfaction of the health board. The need to withhold access to sensitive items within the record should never be used to justify withholding access to the remainder.

14 PRIVACY AND PERSONAL AUTONOMY

14.1 It is desirable that residents in long-term care should have their own room, unless they prefer otherwise, as well as access to communal areas. Spouses who wish to do so should be allowed share a room. Private rooms should be looked after as much as possible by the resident, with staff, in normal circumstances, entering by permission of the resident. Ideally doors should be lockable from both sides, staff members holding a master key. If the rooms in established homes cannot be fully divided to provide private accommodation, every effort should be made to create 'private space' by use of room dividers and other furniture. Residents should be encouraged to 'personalise' their private space with the use of their own soft-furnishings, ornaments, pictures and plants and, as far as possible, furniture. Each resident should have the use of an easy chair in his or her private space, lockable storage and sufficient room for the storage of personal possessions and hanging space for clothing. Residents who so wish should be able to have their own television set, with an aerial or cable link connection. Residents should be able to meet whom they wish in private, either in their own room or some other comfortable accommodation. Privacy and autonomy should also be promoted by the provision of an appropriately positioned or moveable telephone, suitable for use by elderly people, including those who are hard of hearing. Residents who have their own rooms should be able to have personal telephone at their own expense.

14.2 In keeping with the philosophy of residents exercising choice in relation to their care and the manner in which it is delivered, residents in receipt of personal and intimate care should be offered a choice in relation to the gender of the care giver. Such a choice should be presented in a way that respects the dignity of the resident. A careful nursing history taken on admission may prevent unnecessary and embarrassing distress in relation to personal and intimate care required by the resident at a later stage.

15 ACTIVITIES

15.1 Residents who are able should be encouraged to pursue existing interests or acquire new ones and to help around the home, provided that such activities do not interfere unduly with others. Residents who are able to go out alone for walks, shopping and for other social activities should be encouraged to do so. It should be essential courtesy that residents, planning to go out, give an indication of their whereabouts and when they will return. If, after careful assessment, a resident is considered to be too much at risk to go out alone, he or she should be given the opportunity to go shopping with other people. Volunteers may be able to assist with such activities. Residents should be encouraged to make use of community facilities such as community centres, hairdressing, chiropody, the public library and other services. They should also be able to go out freely for trips, meals and longer visits with relatives, friends or volunteers, although they should let staff know of their plans. Transport may need to be organised for some of these activities.

15.2 Activities both inside and outside the home arising from religious and other beliefs should be respected, provided they do not interfere unduly with others.

15.3 It is important that residents who are able to do so be encouraged to take holidays away from the nursing home. Assistance, information and finance may be provided by voluntary organisations.

15.4 Where a person is physically able or has the mental concentration for sustained activities, recreation is important. The resident's day should not be rigidly organised and some flexibility is desirable. Residents should not be got out of bed too early in the morning and should be able to choose when to retire. Regular occupational and leisure activities for residents who wish to participate should be available and should incorporate programmes recommended by physiotherapists and occupational therapists.

15.5 Families and friends of residents should be encouraged to visit regularly and maintain contact by letter or telephone when visiting is not possible. Staff may need to help residents to respond. Visiting arrangements in the home should be open. It should be possible to have visitors late in the evening. Some relatives may wish to assist the resident at meal times or to prepare for bed and they should be facilitated. A resident has the right to refuse to see a visitor, and the registered proprietor should respect this right, accepting responsibility, if necessary, for informing the visitor of the resident's wishes. A registered proprietor may sometimes have reason to believe that it would be contrary to a resident's best interests to see a particular person. If the registered proprietor decides to exclude a person from the home, he or she should record the fact and be able to explain the reasons to the satisfaction of the health board if called upon to do so.

15.6 Television should not be the only entertainment in the evening. The home should encourage games such as bridge, chess, bingo and scrabble. The home should try to ensure that residents who are immobile have company and enable them to go outside. If there is a garden, residents should be encouraged to use it.

16 COUNTERING INSTITUTIONALISATION

16.1 A nursing home should try to create "a home from home" atmosphere. Positive steps have to be taken to counter institutionalisation. Residents need privacy and their individuality and independence must be encouraged, their self-esteem nurtured and their autonomy respected. The daily routine could involve them in activities which are familiar to them and give them control over their own lives. For many residents the feeling of being in control is important. Moves from one bedroom to another should not be made without prior consultation with the resident.

17 RESIDENTS' PROPERTY

17.1 Taking possessions into the nursing home can help people maintain lifelong interests, and can also help create a more homely atmosphere. The number and type of possessions that residents can take with them to the home will depend on the policy of the home. Losing possessions or having them borrowed and not returned can be a source of great annoyance to residents. The problem of looking after possessions may be more acute in homes which have a large number of confused residents. Staff should not treat an individual's property as if it belonged to everyone.

17.2 The question of how a resident's property will be insured should be agreed prior to entering the home or at the latest, when the contract of care is signed. There may be a common policy for the home or residents may be able to extend their existing policies to cover their belongings in the home.

18 VOLUNTARY ORGANISATIONS

18.1 Continuing and active stimulation of all residents is essential to achieve a good quality of life in nursing homes. For those with relatives and friends who visit on a regular basis, such stimulation is more likely than for those who do not have such contacts. Many residents in homes may be without close family ties or friends, possibly because they have had to move some distance from their own homes, or because they have spent time in other institutions. Some residents may have been active in voluntary organisations and may wish to maintain contact with former colleagues. It is in this context that voluntary organisations have an important role to play.

18.2 Volunteers from the surrounding community can do much to lessen the loneliness of residents if they are welcomed into a home. There are several ways in which voluntary helpers can assist. They can befriend individual residents, accompany them to shops, on outings, day-trips, holidays and visits to theatre, assist with letter writing, invite them to their own homes, and offer themselves as agents to act on behalf of the resident to deal with the drawing of benefits and other formalities. It is, of course, essential that the choice of participation in any of these activities remains with the resident. One great value of volunteers is the time they can give to listening to and talking to residents, supplementing the role of staff in social contact.

18.3 If people undertake voluntary work in nursing homes, the person in charge should ensure that they are aware of the stated aims and the philosophy of the home. An agreed description of the role of the volunteers should be written down. All staff should be aware of the particular contribution expected from all voluntary workers.

18.4 Nursing homes should not refuse access to representatives of recognised voluntary organisations who are prepared to organise such activities. There is scope for voluntary organisations to play a more active role in nursing homes than is currently the case. Nursing home proprietors and voluntary agencies should come together to look at more effective involvement by voluntary groups in nursing homes, based on a shared vision and purpose.

19 FINANCIAL AFFAIRS

19.1 People planning to move to a nursing home should be encouraged, tactfully, by their relatives or friends to make a will. Nursing home staff should be able to advise those who have not made a will or their relatives where they may obtain independent advice. Residents or their relatives should not be referred to the registered proprietor's own solicitor. Registered proprietors and staff should not, except in the exceptional circumstances, act as witnesses to any patient's will. In no circumstances should the registered proprietor or any member of the staff become an executor of a resident's will.

20 GIFTS MADE IN THE RESIDENT'S LIFETIME

20.1 What a resident does with his or her money or valuables is a personal decision. However, because of the close relationship and dependence between residents and those who manage and run nursing homes, there is a need for a clear statement about the home's attitude to personal gifts from residents. Ideally, and in order to avoid all suspicion of undue influence, the registered proprietor should make known to all staff and residents that it is the home's practice to decline all personal gifts, except for small token presents. Tipping of staff should not be allowed. A note of this rule together with the prohibition on receipt of all other gifts, save those referred to above, should be included in each staff member's contract of employment. If, however, a resident insists on making a gift, then he or she must be advised to seek independent advice and ideally the registered proprietor or member of staff should also seek such advice before deciding what to do. For nursing staff, the nursing code of ethics provides guidance on this issue.

21 VALUABLES

21.1 Residents should be made aware that they are responsible for the safe-keeping of their own money, documents such as pension books, and other valuable possessions, unless mental impairment makes this impossible. The home should have a secure facility, such as a safe or lockable cupboard with access controlled by the registered proprietor or person in charge. Residents should be encouraged to use this facility and should be given receipts when money or articles are put in it. The home should also keep a permanent register of the items deposited for safe-keeping, the date of deposit and subsequent withdrawal. Arrangements for regular withdrawals and deposits may be necessary. Residents should be fully informed at the time of entering the home, or at the latest, when signing the contract of the insurance cover provided by the home or encouraged to insure their valuables by extending their existing policies.

21.2 If a resident has to be temporarily admitted to hospital or leaves the home for some other purpose, he or she should be able to leave all valuables in the safe or some other secure place and be given a receipt. He or she should be able to return to the same room as far as possible. In the case of the resident's inability to make these arrangements, the person who acts on his or her behalf should take responsibility. While in hospital the room may be used by someone else with the resident's permission.

22 APPOINTMENT OF AGENTS, TRUSTEES AND ATTORNEYS BY RESIDENTS WHO ARE LEGALLY COMPETENT

22.1 A resident may nominate a relative, friend or someone else over the age of eighteen years to act as his or her agent in drawing and making payments. If the resident wants a third party to operate a bank account then he or she can instruct the bank accordingly. The registered proprietor or person in charge should not take on this role unless it has proved impossible to find someone to act on the resident's behalf and after the resident has received legal advice.

22.2 If a resident wishes to delegate more extensive powers, he or she may execute a power of attorney under which authority is given to someone else to act on the resident's behalf. A solicitor should always be consulted when making a power of attorney and in no circumstances should anyone connected with the management of the home be appointed attorney. As a general rule the power of attorney lapses if the resident becomes incompetent.

23 MANAGEMENT OF THE AFFAIRS OF PATIENTS WHO ARE NOT LEGALLY COMPETENT

23.1 The law relating to the management of the affairs of people who are no longer competent is complex. There will be occasions when there is doubt about whether a resident is competent to make decisions on his or her behalf as a result of intellectual changes or physical injury. The law makes some provision for such situations and if any doubt exists about the competence of any resident the registered proprietor or person in charge should encourage the responsible person to seek medical and legal advice.

23.2 Those involved in the running of nursing homes are not under a legal obligation to see that a resident's financial affairs are in order, unless they have become involved themselves in some way. However, if they feel that something, not necessarily of a legal nature, is wrong, and the resident is unable to deal with it, a registered proprietor should draw the attention of the responsible person to the matter. Those connected with the running of a home should observe the principle that they should not become involved in the handling and management of a resident's financial affairs. Registered proprietors and staff are vulnerable to accusations of misconduct if they ignore this principle.

24 COMPLAINTS

24.1 There should be a procedure within the nursing home to deal with in-house complaints, without prejudice to the formal complaints procedure provided in the Nursing Homes (Care and Welfare) Regulations. The resident and the person responsible should be informed of his or her right to make a formal complaint and the procedures for making such a complaint. The resident or person responsible should be reassured that if they make a complaint it will be dealt with confidentially.

24.2 When health board inspections take place residents should be offered the opportunity to speak in confidence with the designated officers of the health board.

25 NEEDS OF SPECIAL RESIDENTS

25.1 Mental Handicap

People with a mental handicap are being admitted with increasing frequency to nursing homes for long-term and short-term respite care. The special needs of these people need to be recognised and liaison where necessary should be made with specialist mental handicap services.

25.2 Younger Residents

While the overwhelming majority of residents in nursing homes will be elderly, younger people will be

admitted for convalescent or respite care. Nursing homes should be sensitive to the needs of younger dependent persons and respect their autonomy. If a home admits a child, the child should be cared for in separate accommodation from older residents and should be offered plenty of opportunities for play. However, a health board may, as a condition of registration, exclude the admission of children.

25.3 Very Dependent Elderly People

Increasingly, residents of nursing homes are highly dependent and need extensive levels of care. Maximum dependency patients are those patients whose independence is impaired to the extent that they require constant nursing care. The person is likely to have very restricted mobility, require assistance with all aspects of physical care or be confused, disturbed and incontinent. As mentioned earlier this group poses a particular challenge to nursing home staff and special attention should be paid to protecting their rights and promoting as much autonomy as possible.

26 SPECIAL NEEDS OF THE TERMINALLY ILL

26.1 Staff of nursing homes should be aware of the special needs of the dying and of the particular skills required in nursing a dying patient. It gives a great sense of security to residents to know that they will not be sent away to die, unless this is unavoidable or because they require the specialist care a hospice can provide. Ideally, intensive or terminal care should be provided in the resident's own room and not in a 'special care unit'.

26.2 A further dimension of care arises in meeting the physical and emotional needs of a dying resident. He or she should be made as comfortable as possible, both in body and mind. Staff need to consider the physical needs and the emotional and spiritual problems of both the resident and family. It is possible that sometimes this care will be best provided in a hospice or hospital. The resident's wishes regarding funeral arrangements should be established prior to the terminal phase of illness.

26.3 When a resident is dying, relatives should be informed without delay and should be able to visit as freely as possible. They should be given adequate support and allowed to stay with the patient if they wish to do so. The use of a single room may be desirable. It may be helpful for relatives to talk about their feelings to members of staff, and staff should give the necessary support. Staff may themselves need support in this work, possibly from outside the home. Staff should be

aware of procedures to be followed when death occurs and news of the death should be conveyed to other residents in a dignified and sympathetic way, even though the death may occur away from the home. It may be appropriate to consider any local or cultural customs as well as any known preferences of the deceased person and his or her family. This may include giving residents an opportunity to see the remains of their deceased friend. In new homes it would be desirable to have a specific room set aside for the laying out of the dead.

NOTES

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