THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1998)21

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

2nd April 1998

Telephone 0131-244
Fax 0131-244 2683

Addressees

For action:
General Managers,
Health Boards

For information:
Chief Executives,
NHS Trusts

General Manager,
Common Services Agency

General Manager,
State Hospitals Board for Scotland

General Manager,
Health Education Board for Scotland

Executive Director,
SCPMDE

Directors of Social Work

Directors of Housing

Chief Executive,
Scottish Homes

Chief Executives,
Unitary Authorities

Health Councils

Enquiries to:

Mr P D Harley
Directorate of Purchasing Strategy
NHS Management Executive
St Andrew's House
EDINBURGH EH1 3DG

Tel: 0131-244 2426
Fax: 0131-244 2970

Dear Colleague

NURSING HOMES SCOTLAND CORE STANDARDS

Summary

1. NHS MEL(1997)34 attached a Core Standards document relating to the care of residents and the inspection and management of registered nursing homes in Scotland.

2. This letter attaches:

(a) revised page 11 to the Core Standards document to replace the existing page. The revision expands at paragraph 3.4.1 the guidance on food hygiene. A copy of the 10 point plan on cooked meat production and the food hygiene checklist is also attached and should be inserted at page 17(a);

(b) the latest Chapter addition to the Core Standards - a chapter on standards for nursing homes registered to provide Palliative Care.

3. The following should be added to the Core Standards "Recommended Literature" section at Page 35:

"No 20. Scottish Office (1992) A Guide to Consent to Examination, Investigation, Treatment or Operation".

Action

5. Health Boards are requested to make this MEL and attachments available to all with an interest in the registration and inspection of nursing homes. The Health Board registration and inspection teams are requested to pass copies of the guidance and attachments to all nursing homes registered in the Health Board area and to make copies available to any prospective nursing home owner on request.

Yours sincerely

KEVIN J WOODS
Director of Strategy and
Performance Management
NHS in Scotland Management Executive

LTS02710

Recycled

3.4 Food and Nutrition

3.4.1 The nursing home will comply with all current environmental health and food safety legislation, good practice guidance and recommendations in every respect, including the "Pennington" recommendation for the prevention of E-Coli infection, that food handlers .... working with vulnerable groups .... and .... in nursing homes be aware of and implement good hygiene practice. Staff should be trained in food hygiene at least to the basic and preferably to the intermediate level. (A checklist for food businesses and a 10 point plan to safer cooked meat is set out at the end of this Chapter.)

3.4.2 Menus should be planned with due regard to residents' choice, cultural and religious preference and nutritional value of the meal.

3.4.3 There should be evidence of monitoring and evaluation of the nutritional state of individual residents and the advice of a dietician should be sought, especially for specialist diets.

3.4.4 There should be evidence that a supply of fresh food and beverages is available in the home for residents 24 hours a day, 7 days a week.

3.5 Pressure Area Care

3.5.1 There should be evidence that nursing practice is based on up to date knowledge, training and research of pressure area care.

3.5.2 All residents should be assessed by a first level registered nurse on admission, using a named risk assessment tool. Reassessment should be undertaken as required.

3.5.3 There should be documented evidence of the practical measures taken to prevent the development of pressure sores in individual cases.

3.5.4 When a pressure sore is identified, there should be documented evidence of comprehensive wound assessment, of therapeutic intervention and of ongoing evaluation.

3.5.5 Nursing homes will provide a suitable and adequate range of equipment for the prevention and management of pressure sores, eg prophylactic mattresses, cushions, as indicated by individual assessment.

3.6 Promotion of Continence

3.6.1 There should be evidence that nursing practice on the promotion of continence and management of incontinence is based on up to date knowledge, training and research of continence care.

3.6.2 There should be written evidence of an initial assessment of continence by a first level registered nurse on admission of individuals to the nursing home.

3.6.3 There should be written evidence of continuing evaluation of continence management and appropriate responses within individual care plans.

SAFER COOKED MEAT PRODUCTION GUIDELINES
A 10-POINT PLAN

Preparation

Always wash your hands before and after handling raw meat.

1. Clean and disinfect the raw meat preparation area before you start. This area must be separate from any area in which cooked meat is handled. A detergent solution should be used to clean surfaces before they are disinfected. It is important to use the correct disinfectant for surfaces and equipment which will not adversely affect the food, and to use it at the appropriate concentration. (For guidance on the use of disinfectants see point 10.)

Cooking

2. To cook meat safely so that *E-Coli 0157*, *Salmonella* and *Listeria* are killed, the centre of the meat must reach a core temperature of at least 70°C for 2 minutes or the equivalent.

3. Make sure your cooking equipment can achieve this consistently. (For guidance see point 10.)

4. The cooking process must be monitored. You should record the core temperature of at least one item from every cook, using a probe thermometer. Wash and disinfect the probe thermometer after each use. Remember to check the accuracy of the thermometer regularly.

Cooling

5. The cooked produce should be cooled as quickly as possible in order to prevent the growth of food poisoning bacteria, and then kept under refrigeration. Remember: the smaller the joint, the quicker it cools.

Handling after Cooking

6. Clean and disinfect the cooked product handling area, which must be separate from any area in which raw products are handled.

7. Always wash your hands before handling cooked products. All equipment must be thoroughly cleaned and disinfected before and after use on cooked foods.

8. Never allow raw foods or any other product used, utensil, tool, or surface likely to cause contamination, to come into contact with cooked foods.

REMEMBER: FOOD POISONING FROM COOKED FOODS OFTEN OCCURS AS A RESULT OF CROSS-CONTAMINATION FROM RAW FOODS

Equivalent Core Cooking Time/Temperature

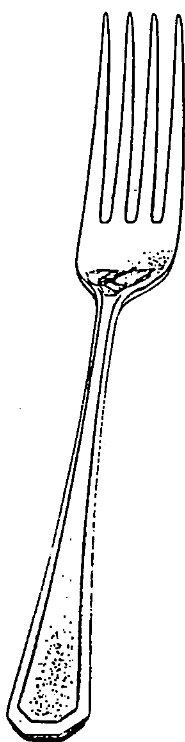
9.

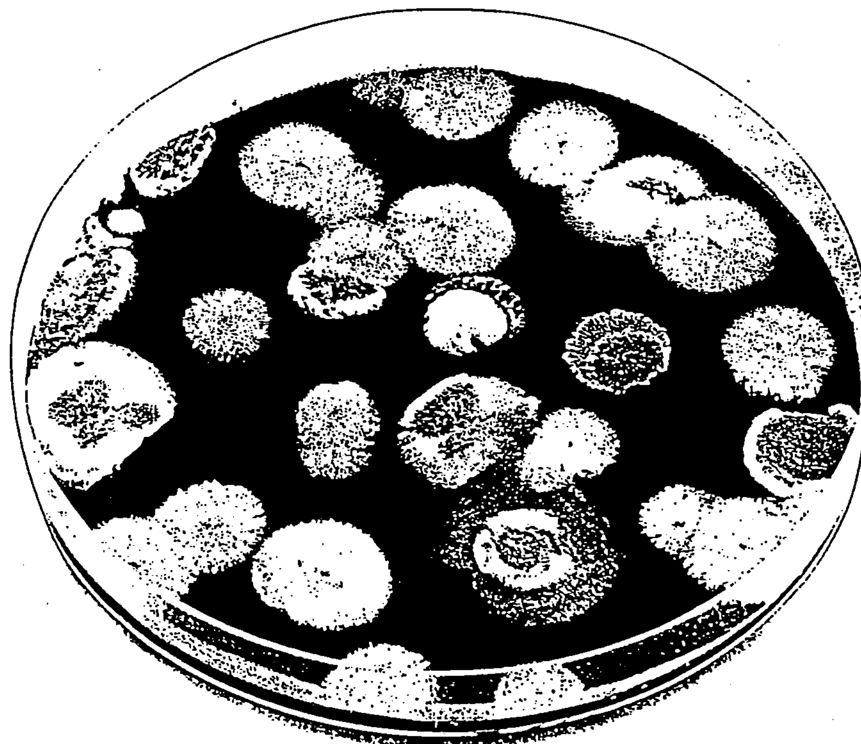
Temperature	Time
60°C	45 mins
65°C	10 mins
70°C	2 mins
75°C	30 secs
80°C	6 secs

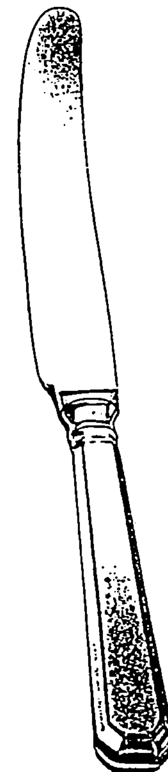
Help Available

10. Your local Environmental Health Officer will be pleased to help you and provide any further advice on the safe handling of foods, and on disinfectants. Help and advice on checking that cooking equipment is working properly may be obtained from the Meat and Livestock Commission, telephone number 01908 677577.

Don't let bacteria become Dish of the Day.







If you produce or sell food for a living, hygiene is a major responsibility. For both you and your employees. Food legislation requires that you identify all steps in your activities which are critical to food safety and ensure that adequate safety controls are in place. The checklist will help you achieve this. For further information, contact your local council's environmental health officer.

Sir David Carter
Chief Medical Officer for Scotland

1. **Provide food hygiene training.** Don't leave anything to chance. Train all your staff who handle food.
2. **Remind staff about the importance of personal hygiene.** It's essential that they wash their hands between handling raw and ready-to-eat food, before starting work, and after going to the toilet, of course.
3. **Get staff to report illnesses.** Employees must tell you when they have an illness like diarrhoea, vomiting or infected cuts.
4. **See that there is enough room to separate raw food from other cooked or ready-to-eat foods.** If it is not possible to keep the two apart, either change the layout of your premises or else reduce the range of foods.
5. **Make sure you have adequate washing facilities.** There should be easy access to sinks and wash basins equipped with hot water and soap.
6. **Take measures to avoid cross-contamination.** Hands, surfaces, equipment and utensils can all spread germs from raw to cooked food. Clean them thoroughly.
7. **Maintain temperature controls.** Check all fridges and freezers operate at the correct temperature. Hot food should be served hot (above 63°C) or cooled as quickly as possible to below 10°C. If re-heated, food should reach 82°C. Use fridge and meat thermometers to check. If you produce cooked meats refer to the "Safer Cooked Meat Production Guidelines".
8. **Have an effective cleaning programme.** Make frequent checks to see your staff are cleaning up after themselves. And that they're using the correct cleaning materials.
9. **Make sure you know your supplier.** Use reputable firms, check condition of goods on receipt and check delivery vehicles, date marks and temperatures.
10. **Regularly monitor your food safety controls.** Review how well your systems are working. Especially if you've changed the way you work or what you sell. If there are any problems, take immediate action.

THE SCOTTISH OFFICE

THE SCOTTISH OFFICE

Department of Health

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

Telephone 0131-244 2426
Fax 0131-244 ~~2683~~ 2970

30 April 1998

Dear Colleague

NHS, MEL(1998)21: NURSING HOMES SCOTLAND CORE STANDARDS

The above MEL dated 2 April 1998 together with changes to the existing Guidance also attached a chapter addition on palliative care to the published guidance on core standards for Nursing Homes in Scotland. I apologise for the fact that the Chapter that was attached was the all but final draft version.

This oversight has been drawn to my attention and while the differences between the copy issued and the agreed final version are minimal, I think it would be a lesser burden on recipients to provide a complete replacement rather than a list of alterations to be made.

I attach the replacement text and apologise again for any inconvenience.

Regulatory Fees for Nursing Homes in Scotland

NHS, MEL(1998)19 which issued on 24 March contains an error at paragraph 7. The statutory reference should be "Section 6 of the 1938 Act" and not Section 1A as listed. Please amend your copy accordingly.

Yours sincerely

PHIL HARLEY

LTS07204

Recycled

NURSING HOMES SCOTLAND
CORE STANDARDS

SECTION 5

NURSING HOMES REGISTERED TO PROVIDE PALLIATIVE CARE

1998

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

NURSING HOMES REGISTERED TO PROVIDE PALLIATIVE CARE

Introduction

The standards which follow set out the minimum required for registration for palliative care. They are supplementary to the Nursing Homes Scotland Core Standards and should be considered in conjunction with them.

The standards are for those nursing homes that currently provide care incorporating the palliative care approach, for residents admitted in the advanced stage of a progressive life-threatening condition and for those Homes considering that provision. Such homes will be assessed by these standards as part of the statutory registration and inspection process.

The new registration category of palliative care replaces the previous terminal illness category but it is not synonymous with it. All nursing homes provide terminal care but, depending on local circumstances, only a number of nursing homes in any Health Board area will be expected to apply for formal registration for palliative care.

This guidance adopts "will" in relation to many action requirements. Health Board registration and inspection teams should always have regard in this context that this does not limit the scope of the Homes to be responsive to individual residents' needs.

The role of a Nursing Home registered for palliative care will be to provide basic palliative care, practising the palliative care approach, in consultation with local specialist palliative care services and with the patient's General Practitioner. Nursing Homes registered in the new category will not be providers of specialist palliative care.

Definitions

The World Health Organisation Definition of Palliative Care states;

Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and *help with* psychological, social and spiritual problems *are* paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with anti-cancer treatment. Palliative care:

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death;
- provides relief from pain and other distressing symptoms;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death and;
- offers a support system to help the family cope during the patient's illness and in their own bereavement.

Forms of Palliative Care

Basic palliative care: The palliative care approach, which should be practised by nursing homes registered to provide palliative care, aims to promote both physical and psycho-social well being. It is informed by a knowledge and practice of palliative care principles and supported by specialist palliative care. The key principles underpinning palliative care which should be practised by all health professionals caring for people with incurable progressive disease are:

- focus on the quality of life which includes good symptom control;
- a whole-person approach taking into account the person's past life experience and current situation;
- respect for patient autonomy and choice;
- care which encompasses both the person with life-threatening disease and those that matter to that person;
- an emphasis on open and sensitive communication, which extends to patients, informal carers and professional carers.

Specialist palliative care: is the active total care of patients with progressive, far advanced disease and limited prognosis, and their families, by a multi-professional team who have undergone recognised specialist palliative care training. It provides physical, psychological, social and spiritual support, including medical and nursing care, social work, pastoral/spiritual care, physiotherapy, occupational therapy, pharmacy and related specialties.

Specialist palliative care is provided by hospices and specialist palliative care units or teams.

Standards

To provide palliative care a nursing home will need an appropriate staff/patient ratio, appropriately qualified staff, specialist equipment and good links with primary care and specialist palliative care services. At least one member of staff will have a Specialist Nurse

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

Practitioner Qualification in Palliative Care or equivalent and be able to act as a co-ordinator/catalyst for the development and training of staff in palliative nursing care skills within the nursing home. Homes registered for palliative care have a place in the total spectrum of services by providing good basic palliative care, complementing specialist palliative care services and other NHS services.

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

PHILOSOPHY

1. A nursing home seeking registration for people requiring palliative care, will have a philosophy encompassing the following:

    (i) Full recognition of the need for an holistic approach to palliation, including management of symptoms and psychosocial support. In this connection managers/owners will have regard to "Palliative Cancer Care Guidelines" published by the Clinical Resource and Audit Group and the Scottish Partnership Agency for Palliative and Cancer Care (1994), (see source documents).

    (ii) An undertaking to make available core staff with knowledge and skills, to plan and co-ordinate care, recognising the need for the residents and their family/carers to be involved in this process. In this connection, the managers/owners will have regard to the "Report by the National Panel for the Dying and Bereaved - The Way Forward" (1997) and "Everybody's Death Should Matter to Somebody" A Review and Recommendations by a Working Group of the Scottish Health Service Advisory Council (1991), (see source documents).

    (iii) An acceptance of and respect for the resident's social, emotional, religious, cultural, ethnic and personal needs, including where appropriate and requested arrangements for pastoral visits to the home by representatives of the residents' religious communities.

    (iv) An undertaking to support residents and their family and friends throughout their stay and into bereavement, with appropriate skills and knowledge, and through liaison with local palliative care services and referral, where requested, and available, to bereavement counselling agencies. Links between the home and the local social work department and acute NHS Trust should also be established.

    (v) A recognition that the GP has overall health care responsibility for the resident.

CARE STANDARDS

2. Nursing Assessment/Care Planning

(i) For planned admissions of residents (or where there is a change of functional status of an existing resident) requiring a palliative care approach a pre-admission assessment will be carried out by a first level registered nurse from the nursing home in consultation as appropriate with the resident's GP and a

member of the local specialist palliative care team. That assessment will as a matter of course take account of any care plan that was in place prior to admission or, in the case of existing residents before the change in the resident's functional status.

(ii) On admission, an initial comprehensive assessment of each resident's needs will be made and documented by a registered nurse with the necessary skills, knowledge and experience to co-ordinate the provision of the palliative care required. (See 4(i)).

(iii) Each resident will have an individual care plan initiated, wherever possible, within 12 hours but not later than 24 hours following admission (or where there is a change of functional status). The care plan will be completed and documented within 2 days. Where the patient's condition allows, the care plan will be developed by the multi-disciplinary team in agreement with the resident and, where the resident wishes, in consultation with his or her relatives/carers. The role of social work services will be taken into account in the preparation of the care plan. Written copies of the care plans will be available on request with the patient's consent, to the social worker or care manager involved in supporting the person, their family or carer, the GP, community nurse or professions allied to medicine involved in treating the person.

(iv) Residents' care plans will be reviewed and documented at least weekly or more frequently in cases when the patient's functional status changes. Every effort should be made to conduct these reviews when the resident's named nurse is available to participate.

(v) Residents will have access to specialist palliative care input in accordance with a policy agreed with the nursing home, the resident's GP and the local specialist palliative care services. Residents and their relatives will be informed about the policy agreed for referrals for specialist care.

(vi) Specialist advice will be sought in those cases where the resident has a mental health problem.

3. **Named Nurse**

(i) All NHS patients in hospital or community settings will have a "named nurse", (paragraph 3.2.1, page 10 refers).

(ii) The named nurse providing a palliative care approach, supported by the specialist nurse practitioner (see paragraph 4(i)) will be trained to such a level as to know when to seek advice from palliative care specialists and to initiate

referral according to a pre-agreed policy with the resident's General Practitioner.

(iii) The named nurse will maintain contact with relatives and offer ongoing support.

(iv) The named nurse will be aware of other support available from the social work department (including for example welfare benefits advice, counselling etc) that may be able to assist the resident or their family and will keep a resource file available for consultation.

MANAGEMENT STANDARDS

4. Staffing

(i) The registered person and person in charge will ensure that as a minimum, one member of staff within each home registered to provide palliative care has formal education and training in palliative care to specialist nurse practitioner level or equivalent, as defined by the UKCC*. The person registered will provide evidence to the Health Board of the education and training undertaken. Where this person is not the person in charge, they will be directly accountable to the person in charge for the development of palliative care expertise.

(ii) The specialist nurse practitioner will be the facilitator for assessments, for co-ordinating palliative care and for relevant in-house training of all staff (nurses, care assistants, ancillary and volunteers) on all aspects of the principles of palliative care. A record of the training programme (in house and other) and staff participation will be kept and be available for examination. (See paragraph 9).

(iii) When residents are receiving palliative care within the home, the registered person must ensure that the staffing levels, skill mix, contingency and holiday cover arrangements meet those specified by the Health Board for the care to be provided.

(iv) The staffing and skill mix at the home will reflect the additional workload entailed in providing palliative care.

(*UKCC stipulate that all nurses are accountable for practice and that this has to be up-to-date)

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

5. **Policies and Procedures**

The nursing home will have clear documented evidence that the following policies and procedures are firmly established in the home, have been prepared in consultation with local specialist palliative care services and GPs and pharmacists and are understood by all staff:-

(i) a protocol for symptom management developed in agreement with primary care and local specialist palliative care services with reference to *"Relief of Pain and Related Symptoms: The Role of Drug Therapy", Scottish Partnership Agency for Palliative and Cancer Care, October 1995)*, (see source documents);

(ii) a protocol for the handling of the dying process, death and bereavement that takes account of the resident's social, cultural, religious and ethnic background;

(iii) a protocol for the continuing contact and support of families and carers;

(iv) a protocol for the support and counselling of staff;

(v) a protocol for the involvement of primary care, secondary care specialist palliative care services, pharmacists and social work services (should be agreed individually with each);

(vi) a protocol for the procurement of specialist equipment and furnishings (including review of latest advances);

(vii) a protocol for the regular checking and maintenance of all equipment;

(viii) a protocol for the storing, giving and recording of all medicines in the Home; including 'out of hours access', (based on pharmacist advice);

(ix) a separate protocol for the storing, giving and recording of medicines for a syringe driver (based on pharmacist advice);

(x) a protocol for the in-house and other training programmes and staff participation;

(xi) a protocol for staff training including regular refresher courses for all nursing staff to enable them to use all available necessary equipment in the provision of care provided and the administration of medicines in the home; a protocol

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

that will include and clearly set out the training programme for qualified nurses to enable them to use a syringe driver. The aim should be to have sufficient staff trained to provide 24 hour cover. ("Commissioning Cancer Services in Scotland" - NHS MEL(1997)17), (see source documents);

(xii) written protocols, frameworks and policies will be available to staff at all times and will be reviewed at least annually and updated in line with current developments;

(xiii) all written protocols, frameworks and policies will be dated, signed and give an indication of when last reviewed;

6. **Accommodation**

(i) The resident and/or relatives will wherever possible be able to choose between single or shared accommodation.

(ii) Accommodation will be available to give residents adequate privacy to receive visitors or to be interviewed in private.

(iii) Provision will be made for relatives or friends to be accommodated overnight if required.

(iv) The care home will have appropriate public utilities including electrical provision for the care and equipment provided at the home.

7. **Equipment**

This is by no means an exhaustive list but represents the minimum equipment that should be immediately available in the home:-

(i) Syringe driver ("Management of Infusion Systems", SOHHD May 1995 refers), (see source documents);

(ii) Drip stand,

(iii) Suction machine with associated equipment and trolley,

(iv) Portable nebuliser,

(v) Electric fan,

(vi) Pressure relieving mattress and other appropriate aids,

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

(vii) Recliner chair,

And, as the needs of residents dictate;

(viii) Oxygen,

(ix) Naso-gastric (NG) feeding pump,

(x) Intravenous infusion pump.

Specific recommendations on the availability of equipment in the community and about training and education is given in the document "Commissioning Cancer Services in Scotland - Primary and Palliative Care Services" (January 1997) (see source documents).

8. **Source Documents**

i. Cancer Pain Relief and Palliative Care. Report of a World Health Organisation Expert Committee. WHO, (1990).

ii. Registered Nursing Homes and People with a Terminal Illness - A Guide to Good Practice. Report of a Working Group of the Scottish Partnership Agency for Palliative and Cancer Care, (1994).

iii. Palliative Cancer Care Guidelines - Clinical Resource and Audit Group and the Scottish Partnership Agency for Palliative and Cancer Care (1994).

iv. Management of Infusion Systems - SOHHD, (1995).

v. Relief of Pain and Related Symptoms: The Role of Drug Therapy - Scottish Partnership Agency for Palliative and Cancer Care, (1995).

vi. Palliative Cancer Care: The Integration of Palliative Care with Cancer Services. Report of a Working Group of the Scottish Partnership Agency for Palliative and Cancer Care, (1996).

vii. A Report by the National Panel for the Dying and Bereaved in Scotland on Future Arrangements for the Care and Dying and Bereaved - The Way Forward, (1997).

viii. Commissioning Cancer Care Services in Scotland - Report of the Scottish Co-ordinating and Advisory Committee Primary and Palliative Care Services, January 1997 - NHS MEL(1997)17, (1997).

All provisions within this section should be read with the general core standards for Nursing Homes set out in the Core Standards 1997 Guidance issued under cover of MEL(1997)34.

ix. Methicillin Resistant Staphylococcus Aureus in Community Settings (Scottish Office 16 May 1996).

x. "Everybody's Death Should Matter to Somebody" - Review and Recommendations by a Working Group of the Scottish Health Service Advisory Council (1991).

xi. NHS MEL(1997)66 - Commissioning Cancer Services in Scotland: Guidance on Pharmaceutical Services and Nursing Services (1997).

xii. Standards of Care for Palliative Nursing - Royal College of Nursing (1993).

9. Postgraduate Courses

Information on post graduate courses is available direct from the National Board for Nursing, Midwifery and Health Visiting in Scotland, 22 Queen Street, Edinburgh EH2 1JX.