



Closure of Care Homes and Relocation of Residents

Best Practice Guidance



Best Practice Guidance

Introduction

1. The purpose of this document is to provide best practice guidance for closing a care home and relocating residents. Research and experience has shown that with careful planning, effective partnership working and the full involvement of residents, their relatives, staff and other professionals, the potential adverse effects from moving residents can be greatly minimised.
2. This document aims to provide guidance that will allow a home closure and relocation of residents to be undertaken in a sensitive, person-centred, tailored way that accounts for the needs of individuals and keeps the health and well being of residents as the primary focus throughout the process.
3. In this document some common risks relating to moving residents have been identified and mitigation measures to manage these risks have been suggested. It is important to note that each home closure will be different and there will be some risks that are unique to that particular home and its residents. It is therefore always important to undertake a full risk review during consultation and monitor throughout each home closure.
4. This document covers the period from the decision to consult on closing a home, through the consultation process, to the decision to close and the relocation of residents to alternative accommodation.
5. Underpinning this guidance are local and national experience, 'best practice', research, government circulars, statute, regulations and case law. Several sources of useful information are listed in the Acknowledgements section.

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Principles and Rights

1. There are a number of legal aspects that need to be fully considered when contemplating closing a home. There are three areas of law which are most significant:
 - a. The duty to consult: there is a requirement that the Council conducts a consultation before making a decision.
 - b. Obligations under the Human Rights Act 1998 (HRA): the Council has obligations to ensure that any actions it takes do not infringe the human rights of residents in the home.
 - c. The Public Sector Equality Duty (PSED): in coming to a decision about the future of the home the Council must be aware of its duty to promote equality.
2. The HRA sets out a number of rights that we all have. Most relevant in relation to the closure of a care home are:
 - a. Article 2 – the right to life.
 - b. Article 3 – the prohibition of torture or inhuman or degrading treatment.
 - c. Article 8 – the right to privacy.
3. A decision which potentially restricts a human right does not necessarily mean that it will be incompatible with the HRA. Public bodies need to take into account other general interests of the community, not just those directly affected by a decision. Some rights can therefore be restricted where it is necessary and proportionate to do so in order to achieve a legitimate aim. Provided a restriction of such a right has a legitimate aim and the restriction itself does not go any further than necessary to protect this aim, then it is likely that it will be compatible with the HRA. In this way the HRA recognises that there are certain situations where a public body is allowed to restrict individual rights in the best interests of the wider community.
4. Should the Council identify that it may be appropriate for one of the homes it owns to close and the capacity at their home is to be provided elsewhere, then closing a home is not incompatible with the requirements of the HRA, providing the Council has done all it reasonably could to minimise the negative impact on the residents.
5. An Equality Impact Assessment (EIA) should be completed in respect of a potential home closure and relocation of its residents. The Council has a statutory duty to promote equality of opportunity, eliminate unlawful discrimination, harassment and victimisation and foster good relations in respect of eight protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
6. Closing care homes and relocating residents is a sensitive issue as it is widely recognised that if not properly dealt with, it can have an adverse effect on the health and well being of the residents involved. It is best practice to keep the number of moves between homes to a minimum.
7. By following the principles below the risk of harm to residents can be reduced to an acceptable level:

- a. Clear, open and honest communication with residents, relatives and staff.
 - b. Communication should be regular and be both proactive and reactive as the situation demands.
 - c. Communication should be personalised and take into account the language and communication mode appropriate to the individuals involved (language, sensory and other impairment needs etc.). Information should be made available in a variety of accessible formats and people should be given time to reflect on the information they have been given.
 - d. When undertaking activities and communicating with residents, relatives, staff and stakeholders it is important to remember that the care home is not just a building to the residents, it is their home.
 - e. Residents should be sensitively encouraged and facilitated to take part in the consultation process about the future of the home in ways that are compatible with their needs and abilities. Professional assessment of their ability to participate and the potential harmful effects of participation should be made.
 - f. Residents should have access to advocacy.
 - g. Residents who fund their own care should be entitled to the same advice and assistance as those funded by statutory organisations.
 - h. All residents should have comprehensive assessments undertaken by appropriate professional(s) and the recommendation of these assessments is to be taken into account in the choice of accommodation offered and in planning their move.
 - i. Residents and their relatives should be offered the opportunity to visit other homes and given time to make an informed decision.
 - j. In planning moves particular attention should be paid to those residents identified as most vulnerable or at risk.
 - k. Consider and protect friendship groups when planning new placements for residents.
 - l. Residents should be given practical help and support to move.
 - m. Residents should not be moved if there is medical advice that to do so would put them at imminent risk. If this is the case moves should be postponed until the risk had been mitigated.
 - n. Regular reviews should take place to monitor the health and well being of the residents who have transferred to the new accommodation.
8. Agencies should work together cooperatively and take account of the following principles when relocating residents:
- a. Safety
 - b. Safeguarding
 - c. Minimising distress and disruption of services
 - d. Dignity
 - e. Choice and control

- f. Independence
- g. Least restrictive options
- h. Respect for family life
- i. Equality and Diversity
- j. Privacy
- k. Realising Potential

Overall Management of Transfers and Care Home Closure

9. Each care home closure and subsequent relocation of residents should be treated as an individual project, adopting 'project management principles'.
10. There should be a named person, who will be accountable for the project, also known as the Project Sponsor. They must have sufficient authority to be able to make decisions, resolve issues and allocate resources. In the Council it is likely that this would be the Assistant Director of Adult Social Care.
11. A Project Board should be established and should be comprised of representatives from the relevant services and specialisms required to deliver the project. These representatives, also known as Workstream Leads, will be responsible for the delivery of actions relating to their service area or specialism.
12. Suggested Workstream Leads to include on the Project Board are:
 - Building
 - Communications
 - Finance
 - Human Resources
 - Operational Management of Home
 - Transitions
 - Legal
13. Depending on the individual circumstances of the home it may be appropriate to include other representatives on the Project Board.
14. The Project Board will make all key decisions, approve plans, manage activities and manage risks and issues.
15. The project should have a Project Manager, who will be responsible for the successful delivery of the project. They will work with Workstream Leads and the Project Sponsor to ensure that work is planned and completed in accordance with agreed criteria.
16. The following project documents should be produced to provide transparency and aid delivery of the project:
 - a. Project Initiation Document (PID)
 - b. Project Plan
 - c. Project Risk Register and Issues Log

17. The Council has standard project document templates which are available from the Social Care, Health and Housing Service Development Team.
18. Project staff will have a presence in the home to ensure successful delivery of the project and support to those directly affected, without interfering with operations and delivery of care within the home.
19. See Appendix 1 for an example of a checklist for the safe and sensitive relocation of residents.

Consultation

20. As previously mentioned in this document the Council has a duty to consult on the future of any proposal to close one of its care homes.
21. Case law sets out a number of principles for the conduct of consultation:
 - a. The consultation must take place when the proposal is still at a formative stage;
 - b. Sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
 - c. Adequate time must be given for consideration and response;
 - d. The product of consultation must be conscientiously taken into account by decision-makers
 - e. The consultation and decision-making processes relating to the closure of a home and relocation of residents must be designed to ensure that these principles are honoured.
22. In addition vulnerable people affected by the proposals (normally the residents) should be supported and facilitated to participate in the consultation process.
23. Staff, as one of the key stakeholders, should be included in the consultation on the future of the care home and should be given the opportunity to submit their reviews and responses. However, the formal HR consultation relating to the future of their employment, would be separate and cannot commence until the decision has been made by Executive to close the home and following the call in period.
24. The Cabinet Office Consultation Principles (last updated 5 November 2013) state that the timescale of consultation should be proportionate and targeted. A care home closure would usually require a 12 week period of formal consultation to enable meaningful engagement with residents, families, carers, staff, general public, Trade Unions and other stakeholders and to provide them with sufficient time to respond.
25. Consultation can be on a specific preferred or 'in principal' option. If there is an amended proposal arising from responses to the consultation, there is no need to start the consultation process again (i.e. views have been listened to). If however, it is a 'new' proposal, then there will be a requirement for further consultation. Whether a proposal is an 'amended' one or a 'new' one requires advice from the Council's legal and consultation experts before any action is taken.
26. It is recommended that a Consultation Plan is produced, that outlines the proposal, the stakeholders and the communication, engagement and consultation activities

required, who will undertake them and by when. Support to produce this is available from the Partnership and Engagement Team in Social Care, Health and Housing.

27. Consultation documents need to be produced, outlining the options considered as part of the evaluation process and the preferred option. It is important to provide sufficient detail to enable people to understand the proposal and the reasons behind it, in order to give their views and make suggestions. However, it is important to recognise that some people may not have the time or the capacity to read a long detailed document so a summary document should also be considered.
28. Consultation and decision-making should be as open and transparent as possible. Residents and relatives and other stakeholders/stakeholder groups directly affected must be involved throughout.
29. Under the principles of the Mental Capacity Act residents may need support to make decisions. The principles of the MCA must be applied when carrying out consultations. Some residents may need support from family members, staff, advocates or Social Workers to be involved in the consultation process. Every effort should be made to gain the views of residents. Following this process, where it is clear that someone lacks capacity, Best Interest decisions need to be made on their behalf.
30. IMCA services should be made available to support residents who lack mental capacity to be involved in the consultation process and who have no next of kin or advocates.
31. Consultation should not be rushed and must be genuinely entered into, with face-to-face contact explaining the reasons for closure being among the methods employed. Residents should be offered an advocacy service (and access to legal advice) if required.
32. The timing and manner of informing residents is critical. It is important that residents, relatives and staff hear the message from Senior Managers in the Council (Director and Assistant Director) rather than through general consultation publicity or the media.
33. Residents' families or close friends may also have feelings of guilt and anxiety and may need special attention and support. Building in enough time to support people is crucial.
34. The Council should keep people well informed every step of the way, making sure the residents, relatives, advocates and staff are among the first to know of any developments. Proactive and reactive communication will be required. People need to be told the facts in a straightforward way, without the use of jargon and in a form that is most accessible to those concerned. In having their say, those involved can share in how and what decision is made and the shaping of any future or alternative provision.
35. A detailed account of the consultation should be maintained throughout the process and a written Consultation Report containing an analysis of all the responses should be produced when the consultation has finished. The Consultation Report would be

made publically available, sent to relevant stakeholders that wish to have a copy and would be used to inform decision-making.

36. Throughout the consultation, consultees will be advised of the timescales involved and it will be stressed that no decision has yet been made.
37. Consultation on the future of a home would need to be completed, a decision made to close the home and call in period before a formal HR consultation can take place with staff at the home about their future employment.

Communication

38. A communications plan should be developed to include consideration of the most appropriate methods, frequency, content and style of communications with residents, relatives, friends, carers, staff, and other stakeholders. Communication methods to consider should include small group meetings, notice board updates, one-to-one and family group meetings and written correspondence.
39. For each home closure project a stakeholder analysis should be undertaken as part of the Communications Plan, to identify the stakeholders and outline how, what and when to communicate with them. The stakeholders that are likely to be included for a care home closure and relocation project are:
 - a. Residents
 - b. Relatives of residents
 - c. Manager and staff at the home
 - d. GPs (existing and future)
 - e. Community Nurse
 - f. Local community
 - g. Other Care Home providers
 - h. Advocacy services
 - i. MPs and Councillors
 - j. Action Groups
 - k. Interest Groups
 - l. Local media
40. GPs should be briefed and involved at an early stage. Multi- disciplinary/agency working is a key requirement to a successful home closure. The relocation may result in a change to the residents' GPs so both the existing and the new GPs would need to be involved.
41. Staff should be supported through group meetings, one to one meetings, staff surgeries, notices on staff noticeboards and written communications. The Home Manager, HR and the Unions should provide key support to staff. It is important that staff understand the different purposes and processes for the consultation on the future of the home and the HR consultation on the future of their employment.
42. Other care homes that the Council contracts with should be kept informed about what is happening. It is important to explain to them how and when it may be appropriate for them to be involved, if at all. If a decision is made to close the home, social workers who would be working with the residents to find them alternative

accommodation, would need to have up to date information on vacancies and care quality.

43. The Communications Plan should include the Council's approach to the media, proactive and reactive press statements and questions and answers.

Risk Management

44. Risks at a strategic, organisational and individual level need to be considered when closing a home. It is critical to assess the risks and undertake mitigation measure to reduce the negative impact of risks and maximise the benefits.
45. Risks should be considered at the start of the project and updated throughout. The production of contingency plans may be required for some risks.
46. There should be a Project Risk Register to document project risks and this should be reviewed regularly by the Project Board.
47. Detailed Risk Assessments should be carried out for the individual residents to assess the specific risks of the move on their health and well being (see Appendix B for a risk assessment template). The assessment should include key risk factors such as heart and lung disease, Parkinson's Disease, previous breakdown, liability to falls/reduced mobility, incontinence, impaired vision/hearing, anxiety/depression/paranoid thoughts, obesity, multiple medication and a history of chest infection (and/or combinations of the above).
48. Although some risks may apply to more than one resident, the way in which the mitigation measures are undertaken will be personalised and tailored to the individuals. It is crucial to incorporate the mitigation measures into the detailed move plan and share with the new home(s) to ensure the negative impact on residents is minimised.

Project Risk Management

49. The way in which a care home closure is carried out can reduce the risk to residents. The following best practice should be considered:
 - a. Allow sufficient time to undertake careful, sensitive and person-centred planning for the closure and relocation of residents. It is suggested that up to 6 months is scheduled for this.
 - b. Have a dedicated social worker who would co-ordinate moves and provide an overarching view of the process and the residents.
 - c. Be flexible and willing to delay a move if a medical assessment of a residents deems them too ill to move or if additional risks are identified that require control measures to be put in place.
 - d. Focus on the needs of individuals rather than looking at the resettlement of the residents as a whole group. Residents should have individual move plans that are co-ordinated as part of the whole move process.
 - e. Move a maximum of 1 resident per day. However, if groups of friends express a wish to move together and suitable staffing arrangements including travelling support can be arranged, then this should be explored as it may be beneficial to the residents. This may be a particular issue towards the end of a managed

- closure when the worry of being one of only a few residents left at the originating home may outweigh concerns about the transfer.
- f. Identify and deploy any additional staff required leading up to and during the relocation. Staff in the receiving homes should also be considered and external resources such as advocacy may be required.
 - g. The social worker should have oversight of the resident in the week up to their planned move. Staff should look for any changes in physical or mental wellbeing which may indicate a higher risk on transfer e.g. loss of appetite, onset of confusion, changes to regular toilet habits etc. If required, medical advice should be sought.
 - h. Continue engagement with residents and their relatives following the move as the time immediately after the relocation and during the first 3 months in the new environment are identified as when the impact of a move is greatest.

Resident Risk Assessment and Management

50. Risk assessments and appropriate health and clinical assessments should be completed in relation to moving residents to new accommodation.
51. Some residents will be more at risk from the move than others. The table below details some of the higher risk residents and the mitigation measures that could be undertaken to reduce the risk of harm to an acceptable level.

Higher risk residents	Mitigation Actions
Residents with dementia and confusion, particularly where there is frailty or an underlying illness.	<p>Good social care practice requires explanation, support, reassurance and more explanation. This may need to be repeated.</p> <p>Use visual aids to help familiarise with new staff and environment before move.</p> <p>Medical examinations on initial assessment and prior to move where appropriate.</p> <p>Follow best dementia practice.</p> <p>Face to face handover between medical and health practitioners if required.</p> <p>Post move ensure additional time spent with resident to help them orientate themselves in new environment.</p> <p>Have familiar layout in new rooms. Include familiar items and music.</p>
Residents requiring specific equipment, (such as pressure relieving mattress, mobility aids, ceiling track host and hi-lo bath)	<p>Review of equipment needs prior to move.</p> <p>Identify what equipment can be transferred with the resident.</p> <p>Equipment provision to be checked at new home before moving.</p> <p>Ensure staff at the receiving home are trained to use the equipment.</p>
Residents with special dietary needs and those who require	<p>Support plans to be reviewed to ensure full information is included.</p>

support to eat or use artificial feeding (such as PEG) methods.	Briefing and training of staff at receiving home by current staff. New staff to understand the likes and dislikes of residents.
Residents that suffer from stress and anxiety over changes.	Full briefings on effects of stress and anxiety to all involved in supporting residents. Ensure all staff (current and new) can recognise and manage stress and anxiety. Involvement of the resident and relatives in the choice of home and options. Facilitate visits to new homes wherever possible. Introduce new care staff before the move. Friendship groups will be considered and protected. Receiving home to allocate key worker to support people prior, during and following the move.

Social and Health Care Assessments:

Individual Residents

52. Establishing effective relationships at the start of the process and sustaining them is important. A Social Worker should be identified at an early stage and should see the project through to the end, supporting the transfers and undertaking the post move reviews.
53. An up-to-date care and support assessment should be completed for each resident as the main way of identifying a suitable care setting/supported housing option as an alternative to the originating home. The assessment should also specifically address the impact of a move on the resident. The resident would be involved in the assessment process in line with the principles of the MCA (e.g. supported decision making).
54. The nominated care manager should ensure that all relevant health professionals contribute, including an Occupational Therapist. The views of family/next of kin should also be sought. The resulting support plan should address all aspects of care, but must also include information such as dietary needs and “likes/dislikes”, spiritual and/or cultural needs and other specific requirements which may be particularly important to the individual resident. This information will be shared with the receiving home.
55. The Social Worker in collaboration with health colleagues should complete a CHC checklist if it is deemed that the resident may have nursing needs.
56. In the event of a safeguarding concern within the existing or new home, the practitioners should follow normal practice, must seek the advice of the Safeguarding Team and respond accordingly.

57. Each resident should be individually assessed for their suitability to transfer and to ensure that any new provider agrees that their needs can be fully met in the receiving home. The support plan should be reviewed a few days immediately before transfer to ensure that it is completely up to date.
58. Clear arrangements for the medical transfer of each resident must be made prior to any relocation. A patient summary should accompany the resident to their new residence, on the day of transfer.

Safeguarding

59. The resident's safety is paramount during the period of transition. Central Bedfordshire Council has a suite of multi agency safeguarding policies and procedures to support practitioners in assessing safeguarding risks and putting in place appropriate protection plans. Refer to the Council's Safeguarding Handbook for detailed guidance. The Council is the lead agency for safeguarding adults at risk, but all agencies working with adults at risk within Central Bedfordshire are required to work within the safeguarding policy and practice framework.
60. The definition of an adult at risk is: a person 18 years and over (whether or not eligible for community care services) who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation. The definition of safeguarding adults at risk is: all work which enable an adult who is or may be eligible for community care services to retain independence, well being and choice and to access their human right to live a life that is free from abuse and neglect.
61. If practitioners believe they are working with a person who is at risk from abuse, neglect, discrimination, harm or exploitation, they must report the concern to the safeguarding team or report the concern using the safeguarding alert form. If concerned about a crime or the immediate safety of a person, practitioners should call the police.

Mental Capacity Assessment

62. In the Mental Capacity Act 2005 Section 1 it states that a person must be assumed to have capacity unless it is established the he or she lacks capacity. In seeking to determine whether a person has sufficient mental capacity to make a particular decision the following principles must be followed;
 - a. A person must be assumed to have capacity unless it is established that he lacks capacity
 - b. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
 - c. A person is not to be treated as unable to make a decision merely because he makes an unwise decision
 - d. Any action carried out, or decision made, under this act or on behalf of a person who lacks capacity must carried out, in his best interests.
 - e. Any action carried out on behalf of the person who lacks capacity, must be the least restrictive option. It is important that residents understand why they have to move and what is involved in moving. Should practitioners have any doubt

about a person's capacity to make a decision or informed choice, a Mental Capacity Assessment should be undertaken to determine the client's ability to;

- Understand and retain the information relevant to the decision
- Make a decision based on the information, at the moment a decision needs to be taken
- Communicate a decision or view of how they want to receive care

63. Practitioners should involve other professionals, advocates, family and carers as appropriate to assist with making a judgement about a person's capacity.

64. Guidance on the MCA and a copy of the Mental Capacity Form can be found in the Council's Safeguarding Handbook or from the Mental Capacity Act 2005 Code of Practice.

Best Interest Assessment

65. If a person lacks the mental capacity to make a decision, then action must be taken in their best interest. A best interest assessment must take place. 'Best Interest' is not defined in the Act but certain factors must be taken into account in order to decide what is in a person's best interest.

66. Some of the factors to take into consideration when carrying out a Best Interest's assessment are:

- Do not discriminate. Do not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect their behaviour.
- Take into account all relevant circumstances
- If faced with a particularly difficult or contentious decision, it is recommended that practitioners adopt a 'balance sheet' approach
- Will the person regain capacity? If so, can the decision wait?
- Involve the individual as fully as possible
- Take into account the individual's past and present wishes and feelings, and any beliefs and values likely to have a bearing on the decision
- Consult as far and as widely as possible.

67. Again, it is vital that the best interests decision is recorded. Not only does this concur with good professional practice, but given the evidence-based approach required by the MCA, there will be an objective record should the decision or decision-making processes later be challenged. For more detailed information refer to the Mental Capacity Act Code of Practice

Deprivation of Liberty Safeguards (DoLS)

68. The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty (within the meaning of article 5 of the Human Rights Act) in a hospital or care home. They do not apply to people detained under the Mental Health Act 1983. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable, but in a person's best interests.

69. A DoLS would need to be requested by the new home in the following circumstances;
 - a. If someone lacks the capacity to say whether or not they want to be in the care home in order to receive care or treatment
 - b. If someone is not free to leave the care home
 - c. If they are under continuous supervision and control
70. Further details can be found in the Council's Deprivation of Liberty Safeguards Code of Practice.

Arrangements for Residents to Transfer

71. An identified Social Worker should be available for each resident and their relatives/carers to provide advice and support on vacancies, preferred area and choice of accommodation.
72. Plenty of time and opportunity should be provided for residents to visit and try out new homes, preferably accompanied by someone they know. This process should not be rushed, but taken at the pace of the resident.
73. Discussions should take place between the home's management team, the social worker, residents and their families regarding the best way to transfer from one home to another. The homes' management team would need to ensure that sufficient staff are available to support the transition. This would normally mean not more than one resident moving per day.
74. Following assessment, the individual support plan should be reviewed and updated within 1 week prior to transfer. A formal review of each resident should be conducted within 2 working days of transfer and at approximately 4 weeks, 3 months and, as business as usual 12 months after transfer. A re-assessment should take place if needs significantly change within this time frame. As is standard practice for formal reviews, all relevant parties would be invited to be involved and adjustments will be made to the support plan if required
75. It is good practice to undertake life story work with residents. The aim of the life story is to enable people to affirm and maintain their identity and personhood through the creation of their own life story. Writing down their words is a way of capturing the things that have been and remain important to them in their life. As well as helping residents to reminisce it is also a way of bringing the person to life for staff who do not know them. This model is in line with policy initiatives to develop more person-centred care and enabling individuals to exercise choice and control. Knowing people better as individuals enables staff to provide more tailored and appropriate care, which can reduce frustration and agitation.
76. Visits to prospective homes or supported living homes should be arranged where practicable. Having a meal at the new home may also be a good way of the resident getting to know a prospective home.
77. Originating care home staff members should spend time with the individual resident in their new environment as an important part of the settling in period. The new

home's should also become familiar with the resident and their support plan prior to transfer – including familiarity with dietary and other relevant needs.

78. The social worker should oversee the move plan and any documentation for individual residents and ensure that it is fully developed and accurate, for transfer with that resident to their new accommodation.
79. In setting up the arrangements for transfer, it should be made clear to the registered manager of any receiving residential or nursing care home that they are empowered to refuse the transfer of a resident if they are not happy that all suitable arrangements have been put in place and that the support plans etc. are absolutely clear.
80. The social worker should ensure that contact is made with each of the receiving homes/housing providers in the 24 hours before the date of the planned transfer of any individual as a final check to ensure they are fully prepared to accept the older person the following day.
81. Transport arrangements should be made ensuring that the vehicle is suitably equipped to accommodate the needs of the individual resident. Ideally a carer, family member or a trusted member of staff would accompany the resident and offer support during the journey.
82. Any resident who is considered not to be physically well enough to move should have their transfer date put back until well enough to transfer to the new home. Appropriate medical involvement should be sought and appropriate staff involved in the assessment and treatment of the person. The social worker, registered manager or identified member of the care home management team on duty at the originating home on the day of transfer would have the authority to cancel or postpone the move of a resident if they have any doubts as all that it is appropriate or safe on that day. They should have the support of senior managers to take this decision.
83. The clothing, possessions and furniture of residents should go with them to the new establishment so that their new environment is as familiar as possible from their day of arrival. Suitable bags would be available, ideally suitcases, either the resident's or relatives or purchased by the Council. These would be made identifiable through labelling. On no account should black bin bags be used.
84. Those with visual impairments should be assisted by making the layout of the surroundings similar to that they have been used to. They are likely to need time and help to get used to the new layout. Photographs may be taken of the current room and added to the care plan/life story to ensure the layout is correct.
85. The residents should be allowed the opportunity to say goodbye to friends and staff in their own time. Staff may want to say goodbye so they would be kept informed about the moving arrangements.
86. The new care staff should offer support with unpacking and provide emotional support.

87. The social worker should liaise with the Department of Work and Pensions if needed to aid the transfer of pensions and avoid delays following transfer unless the resident or family member/other with legal status prefer to manage these arrangements.
88. The social worker should identify, in liaison with the resident, relatives and carers, who needs to be informed of the change of address and new contact details for the re-locating resident. Moving cards could be provided to inform relevant others of their new address.

Move Plan

89. The move plan must include the following details;
 - a. Name of the person moving
 - b. Name and address of their new home
 - c. Name of social worker responsible for overseeing the move
 - d. Name(s) of family or friend who wish to be involved in the actual move
 - e. Date and time of the move
 - f. Name of the person responsible for making an inventory of the resident's belongings
 - g. Details of the transport required and any specific mobility needs
 - h. Name of the person responsible for;
 - a. redirection of mail
 - b. informing DWP of new address
 - c. health assessments
 - i. Name of current funding authority
 - j. Details of Local Authority if moving out of area
90. A move plan template is attached as Appendix D.

Transfer of Health Care Data and Responsibilities

91. The residents' own GP should be asked if they have any medical advice to give concerning the transfer and where possible should be asked to continue the care of the person after the move.
92. Arrangements should be initiated by the receiving home for a GP to be appointed as soon as possible after the transfer of any resident to a new care home.

Communication with Relatives, Friends and Carers

93. Consideration should be given to the impact of care home closure upon carers and any other people, especially those in vulnerable people. This information should inform the consultation and equalities impact assessments, and contribute to the decision making process.
94. Throughout the process of announcement, consultation, decision-making and implementation, relatives, friends, representatives and carers should be offered appropriate information, advice and support. This should include one-to-one meetings, group meetings correspondence and information in the home, as appropriate to the circumstances and the wishes of the people concerned.

95. Having a regular presence of people involved in the process in the home will allow for residents, relatives and staff to receive informal and responsive advice and support and will also allow members of the transition team to get a fuller picture of the needs and preferences of residents outside of the formal assessment processes.
96. Monitoring and review of the wellbeing of vulnerable adults should be undertaken at appropriate intervals. This will underpin the identification of further good practice and lessons to be applied in the continuous updating of this guidance and our procedures.

Follow-Up

97. Acknowledgment and thanks to be given to those involved in the process, for their cooperation and assistance following all moves.

Debrief, Feedback and Lessons Identified

98. Formal team debriefing, longer term review of residents and evaluation of the closure, procedures used and lessons learnt should be reviewed within six weeks of the closure.
99. Residents' views of the relocation process should be sought within three months of the transfer to the new home. This will provide evidence of the effect the closure has had on residents and will feed into the overall evaluation of the re-provision.
100. It is recommended that this guidance is reviewed and updated following changes to best practice, relevant legislation, Council policy and experience of undertaking the work.

Acknowledgements

Association of Directors of Adult Social Services: *Achieving Closure, Good practice in supporting older people during residential care closures*, 2011.

Personal Social Services Research Unit: *Guidelines for the closure of care homes for older people*, October 2003.

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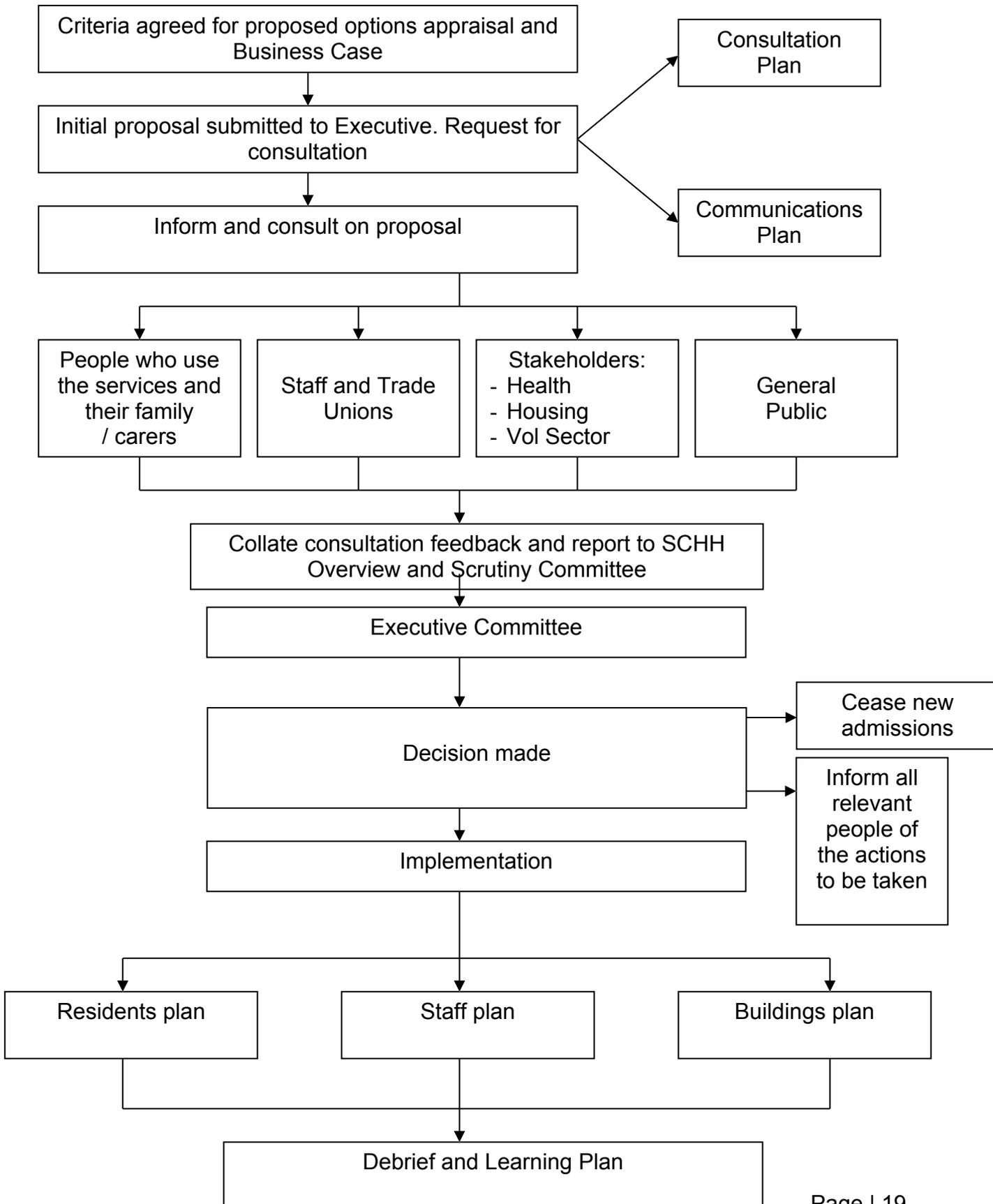
Social Care Association, *Managing Care Home Closure*, 2011.

South Gloucestershire Council, *Better Support for Older People Project - Protocol for Care Home Re-provision and the Relocation of Residents*. 2007.

Central Bedfordshire Council: *Closing a Care Home, Good Practice and Learning 2014*

Appendices

Appendix A Example Process for In-House Planned Closure



Appendix B Resident's Risk Assessment and Mitigation Template

Vulnerability factors	Yes	No	Details	Level of risk H/M/L	Mitigation Measures	Level of Risk after Mitigating Measures H/M/L
Complex Health needs? Eg: lung/heart disease, chronic conditions						
High Waterlow score?						
High MUST score?						
Concerns re BMI?						
Mobility risks: falls/non weight bearing?						
Visual impairment?						
Hearing impairment?						

Vulnerability factors	Yes	No	Details	Level of risk H/M/L	Mitigation Measures	Level of Risk after Mitigating Measures H/M/L
History of UTI?						
Has the resident's health deteriorated recently?						
Has the person capacity to choose where to move?						
Anxiety/depression/paranoia/ Dementia/confusion?						
Behavioural Concerns?						
Risk of isolation as a result of the move?						
Are there concerns from						

Vulnerability factors	Yes	No	Details	Level of risk H/M/L	Mitigation Measures	Level of Risk after Mitigating Measures H/M/L
<p>health professionals regarding the move</p> <p>Has this information been shared and discussed with the GP?</p>						
<p>Any other concerns?</p>						

Appendix C**Pre-Move Evaluation**

Name:		Swift ID	Date
Question	Answer	Mitigation Measures	
What things are important to you to take place before the move ?			
What things are important to you to take place during the move , e.g. possessions/people/information?			
What are your concerns about the move?			
What things are important to you to take place once in your new home?			
Is there anything else we need to take into account			

Appendix D

Resident's Personalised Move Plan and Checklist

Name of Resident:	Curent Home: Name of New Home:	Current Room No. New Room No:
Name of Family /Friend/ advocate involved and contact numbers.		
Name of Social Worker Responsible for overseeing the Move and contact number.		
Name of Professionals involved and contact numbers.		

Name of Resident:

Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
Meet with residents and relatives to discuss the final decision of the future of the home and plan for move to new residence				
Complete MCA regarding choice of new home and arrange advocate if required (IMCA)				
Completion of pre move expectation evaluation				
Social work assessment of need and risks (Care and Support Assessment)				
Application for Continuing Healthcare (CHC) if appropriate				
Update resident's move risk assessment				
Professional Assessments <ul style="list-style-type: none">Assessment by manager of new				

Name of Resident:

Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
home <ul style="list-style-type: none"> • Occupational Therapy (OT) • GP • Community Matron/District Nurse • Psychiatrist • Other 				
Complete integrated care and support plan				
Identification of new home				
Gain funding approval				
Notify finance of new residence (BSU form)				
Inform family of contact details of new home				
Familiarising residents of new homes, e.g. photos, verbal descriptions etc.				
Life story work				
Identify key worker from				

Name of Resident:

Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
new home				
Arrange visits from key worker/carers from new home				
Arrange for visits to new home where able				
Identify appropriate equipment and vehicle for resident transfer				
Identify transport for furniture				
Confirm time and date of move to new home				
Arrange residents' transport date and time				
Confirm who will accompany resident to new home				
Arrange transport date and time for furniture to be moved				
Arrange for receipt of				

Name of Resident:

Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
furniture at new home				
Identify who will pack and unpack belongings				
Inventory of belongings/clothing				
Inventory of furniture				
Labelling of belonging, clothing and furniture				
Ensure appropriate suitcases/packing materials in place				
Ensure equipment in situ in new residence				
Pack belongings				
Ensure GP patient summary (list of medication) is ready to transport with resident				
Ensure Medication stock/prescription transfer sheet complete and ready to transfer with resident				
Ensure continence pad supply in place at new				

Name of Resident:

Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
residence				
Hearing aids checked and supply of spare batteries in situ				
Existing home to close personal allowances and return any money to families				
Organise moving cards				
Out of County;				
Liaise with other local authorities re contract rates				
Identify new home options at contracted rates				
Panel request if CBC resident moving out of county				
Completion of Brokerage form to notify of new residence (BSU)				
Inform new home of finance contact				
Identify arrangements re				

Name of Resident:

Details of action required	Completed Date/initials	Comments	Outstanding issues	Completed
reviewing placement				

Appendix E Post-Move Checklist

Name:		Swift ID:	Date:
Question	Answer	Issues to Address	
How have you/your relative settled in?			
Was everything ready for you before you moved to your new home?			
How was the move - what went well?			
What didn't go well during the move?			
Was everything ready for you when you arrived at your new home?			
Is there anything else we should be aware of?			



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