NICE National Institute for
Health and Care Excellence

Home care: delivering personal care and practical support to older people living in their own homes

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS123.

Overview

This guideline covers the planning and delivery of person-centred care for older people living in their own homes (known as home care or domiciliary care). It aims to promote older people's independence and to ensure safe and consistently high quality home care services.

The Care Quality Commission uses NICE guidelines as evidence to inform the inspection process.

Who is it for?

- Health and social care practitioners

- Home care provider organisations

- Home care managers and workers

- Older people using or planning to use home care services, and their carers

Commissioners of home care services should ensure any service specifications take into account the recommendations in this guideline.

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Ensuring care is person centred

1.1.1   Ensure services support the aspirations, goals and priorities of each person, rather than providing 'one size fits all' services.

1.1.2   Ensure support focuses on what people can or would like to do to maintain their independence, not only on what they cannot do. Recognise:

- that people have preferences, aspirations and potential throughout their lives, and

- that people with cognitive impairment and those living alone might be at higher risk of having unmet social care-related quality of life needs or worse psychological outcomes.

1.1.3   Ensure people using home care services and their carers are treated with empathy, courtesy, respect and in a dignified way by:

- involving people and their carers in discussions and decisions about their care and support

- agreeing mutual expectations

- always respecting confidentiality and privacy

- providing a reliable service that people and their carers can trust

- regularly seeking feedback (both positive and negative) about the quality and suitability of care from people using the service, including those who do not have a carer or advocate.

1.1.4   Prioritise continuity of care by ensuring the person is supported by the same home care worker(s) so they can become familiar with them.

1.1.5   Ensure there is a transparent process for 'matching' care workers to people, taking into account:

- the person's care and support needs, and

- the care workers' skills, and

- if possible and appropriate, both parties' interests and preferences.

1.1.6   Ensure the person using the service, and their carers (if the person has involved them in their care), can direct the way home care is delivered. This is so that the person's safety, comfort, independence and sense of security are always promoted.

1.2   Providing information about care and support options

1.2.1   Give people who use or who are planning to use home care services and their carers details of

- Different funding mechanisms including self-funding and the options available for people with personal budgets and support to manage them. Examples of funding mechanisms include having a managed budget, an individual service fund or direct payment.

- Where to find information about the range and quality of services available (for example, the Care Quality Commission ratings), the activities they offer and how much they cost.

- What needs the home care services are able to address, for example, personal care (help with tasks such as getting in and out of bed, washing and bathing, going to the toilet, dressing or eating and drinking) and help with housework and other services to help people remain safely at home and in their community.

- Other options, such as:

  — saving allocated hours to be used at a later date (sometimes known as 'timebanking')

  — options such as a live-in care worker or 'shared lives' (where the person stays in the community by living with another person or a family)

  — employing personal assistants

- telecare (technology that provides support and assistance to people with social care needs).

  In line with the requirements of the Care Act 2014, local authorities must also establish and maintain a service that gives everybody in the local area: information about how to access care and support; information about what support is available and who provides it; independent financial advice; and details of how to raise concerns.

1.2.2 Offer people and their carers information about local and national support groups and networks, and activity groups.

1.2.3 Ensure people using services and their carers have information that supports them to make informed choices about their care, including:

- what to expect from the home care service, and

- their rights, and

- what they should do if they are not happy with the service (see recommendations 1.4.5 to 1.4.7 in the section on delivering person-centred home care).

  Consider presenting this as part of a 'welcome pack' (or equivalent).

1.2.4   Offer the person a written summary of the information that has been provided to them (or provide this summary in another format that meets the person's needs). Be aware that the circumstances that lead people to need home care can be traumatic and people may find it difficult to take in a lot of information.

1.2.5   Tailor all information for different audiences to ensure it is accessible and understandable. Ensure information is:

- easy to read and in plain English

- available in the person's language if needed

- available in different formats and media (including, for example, information packs, telephone hotlines and electronic media)

- advertised or made available in different locations, such as community centres, GP surgeries and pharmacies, as well as through face-to-face meetings with a social care practitioner

- provided in formats that suit people with different communication or capacity needs, for example, large-print, braille or audio versions.

1.2.6   Ensure that information is updated regularly. Design information in a way that allows it to be updated easily.

1.3   Planning and reviewing home care and support

Strategic planning of home care

1.3.1   Recognise home care as an important component of care packages for older people.

1.3.2   Consider home care support for older people with low to moderate needs to avoid, delay or reduce future dependency on health and social care services.

1.3.3   Ensure home care packages address social care-related quality of life and the person's wider wellbeing (for example home cleanliness and

comfort) in addition to practical support. Recognise that people who use home care services often need support that goes beyond their personal care needs.

1.3.4   Give people choosing direct payments for home care the support and information they need to manage the payments effectively. This should be regardless of whether they buy care through a regulated provider, directly employ a personal assistant or choose another way to meet the agreed need.

1.3.5   Consider involving people with experience of using a direct payment for home care to help provide training, support or advice to others thinking of doing so.

Coordinating home care

1.3.6   Consider identifying a named care coordinator from among the people involved in delivering care to:

- lead home care planning and coordinate care

- ensure everyone involved in delivering care and support knows what they should be providing and when

- ensure everyone involved in delivering care and support is communicating regularly.

1.3.7   Ensure integrated care and support is delivered to the person through a coordinated group of workers (where care involves more than one practitioner). The composition of this group should reflect the person's needs and circumstances, and should recognise the expertise, knowledge and commitment of all members. Members might include, for example:

- home care managers and workers

- carers

- healthcare practitioners, for example district nurses, GPs

- social care practitioners, for example social workers

- people from voluntary and community organisations, befriending and specialist services, for example dementia advisers

- advocates, including those appointed by the Court of Protection.

Planning home care

1.3.8   Ensure that the named care coordinator and others involved in home care and support planning (in line with the recommendations in the section on ensuring care is person centred):

- understand the principles and importance of involving the person using services, and their carer(s), as appropriate, as an equal partner in specifying the support and services they receive

- know how to work in a way that maximises choice, control, dignity and respect for the person using services

- understand common conditions affecting people using home care services, for example, dementia, diabetes, mental health and neurological conditions, physical and learning disabilities and sensory loss. NICE has produced guidance that covers referral and management strategies for many of these conditions

- know about local and national organisations that provide specialist support

- know about the funding options available for care and support

- understand different funding mechanisms including the options available for people with personal budgets, for example having a managed budget, an individual service fund or direct payment.

1.3.9   Give named care coordinators and others involved in home care planning and support relevant information about a person's circumstances before the home care planning process is started.

1.3.10   Give the person using services and their carer information about how the home care plan will be developed, negotiated and reviewed and the options available to them. Ensure this information is made available to

people before home care planning meetings and that they have enough time to read and understand this information.

1.3.11 Ask people if they want carers or advocates involved in their home care planning and support, and respect their choice.

1.3.12 Consider planning support that enables the person to take more responsibility, including for their own financial arrangements for care and support, to increase their independence over time.

1.3.13 Ask people about their aspirations, needs and priorities, as well as what gives them peace of mind, and makes them feel safe and unsafe. Ensure the home care plan:

- empowers the person as much as possible, by recognising what they can and want to do

- explicitly addresses safety, wellbeing, independence and any specialist needs

- is informed by the experience, skills and insight of carers, as appropriate

- addresses the full range of support needed to help the person to live how they choose, including practical support as well as personal care needs (this could include, for example, support to help a person manage their own financial and personal affairs, do their own shopping and cooking, or socialise, or other help depending on the person's needs and preferences)

- makes explicit the role to be played by family and other carers, and the need for review if their circumstances change

- describes how success and outcomes will be measured

- is clear, concise and easy to navigate

- has a summary at the start, with links to more detailed information.

1.3.14 When assessing risk, balance the risk of a particular behaviour or activity with how it is likely to benefit the person's wellbeing and help improve their quality of life. The named care coordinator, or other practitioners planning home care, should:

- complete a risk plan with the person as part of the home care planning process and include this in the home care plan

- ensure the risk plan includes strategies to minimise risk, for example specialist equipment, use of verbal prompts, use of support from others

- ensure the risk plan includes the implications of taking the risk for the person and the care worker

- carry out risk assessments as part of home care planning and at relevant intervals, such as when significant factors change.

1.3.15   Social care practitioners should liaise with healthcare practitioners and other people involved in the person's care and support to ensure the home care plan promotes wellbeing, particularly in relation to:

- medicines management

- pain management

- overall skin integrity and preventive care.

1.3.16   Write any medicines management requirements into the home care plan including:

- the purpose of, and information on, medicines

- the importance of dosage and timing, and implications of non-adherence

- details of who to contact in the case of any concerns.

1.3.17   Always discuss with the person and their carer whether telecare could complement their home care package (and any other services they are using).

1.3.18   Discuss the potential benefits of telecare, such as how it can provide reassurance to the person and their carer, while bearing in mind the rights of a person, particularly in relation to privacy, choice and control.

1.3.19   Consider addressing the potential negative effect of social isolation on people's health and wellbeing. Consider involving voluntary sector and community organisations to maintain family and local community links,

working with the carer as appropriate.

1.3.20   Ask people:

- which elements of their home care service are a priority for them, and

- whether they want some home care time to be used flexibly (that is, used for a
  variety of jobs according to what is needed).

Access to and review of home care plans

1.3.21   Give people and their carers (with the person's permission) a copy of
         their home care plan in a format that meets their needs.

1.3.22   Ensure a 'care diary' (or 'care record') is kept in the person's home. This
         is a detailed day-to-day log of all the care and support provided, which
         also highlights the person's needs, preferences and experiences. Offer
         the person a copy of it.

1.3.23   Home care workers should ensure the care diary completed routinely on
         each visit is detailed enough to keep people, their carers and
         practitioners fully informed about what has been provided. Record any
         incidents or changes. Read new entries if you have not seen the person
         recently.

1.3.24   Ensure all people involved in providing care and support have access to
         the home care plan and to the care diary. Encourage them to read and
         contribute to both documents, as appropriate.

1.3.25   Undertake an initial review of the home care plan within 6 weeks, then
         review regularly, at least annually.

Planning telecare

1.3.26   If the person wishes to use telecare, work with them to identify their
         preferred telecare options that maximise dignity and help them live in the
         way that they choose.

1.3.27   Ensure telecare does not replace personal contact, unless the person using services wants it to.

1.3.28   Record in the home care plan how the telecare equipment meets the person's needs and will help them achieve their desired outcomes.

1.3.29   Offer people using home care services information about options for telecare that could help them. Include information on potential risks and benefits, so they can make an informed decision.

1.4   Delivering home care

Contracting home care

1.4.1   Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments. (This is aligned with the Care Act 2014, which requires commissioners to pay due regard to all costs associated with delivering care and support.) They should ensure that workers have time to do their job without being rushed or compromising the dignity or wellbeing of the person who uses services.

1.4.2   Home care visits shorter than half an hour should be made only if:

- the home care worker is known to the person, and

- the visit is part of a wider package of support, and

- it allows enough time to complete specific, time limited tasks or to check if someone is safe and well.

1.4.3   Consider contracting and monitoring in a way that allows services to be delivered flexibly to ensure the person can identify what is a priority for them. This might include, for example, allowing provider organisations (with the person's agreement or at their request) to use time flexibly.

Delivering person-centred home care

1.4.4   Ensure home care visits are long enough for home care workers to complete their work without compromising the quality of their work or the dignity of the person, including scheduling sufficient travel time between visits. Take into account that people with cognitive impairments, communication difficulties or sensory loss may need workers to spend more time with them to give them the support they need. Some may need workers to spend more time helping them eat and drink.

1.4.5   Ensure there is a complaints procedure in place. Tell people about how they can make a complaint either in writing or in person.

1.4.6   Make the complaints procedure available on your website and in other ways appropriate to people using the service and their carers. Give information about escalating complaints (to the commissioning body and Ombudsman) or ensure this information is readily available.

1.4.7   Ensure continuity of care so that the person knows the home care workers and the workers are familiar with how that person likes support to be given, and can readily identify and respond to risks or concerns, by:

- introducing people to new home care workers, and

- building teams of workers around a person and their carer, and

- informing people in advance if staff will be changed and explaining why, and

- working with people to negotiate any changes to their care, for example when visits will be made, and

- recognising that major changes (for example moving from home care to use of personal assistants) can make people feel unsafe.

1.4.8   Ensure home care workers are able to deliver home care in a way that respects the person's cultural, religious and communication needs and reflects all 'protected characteristics' in the Equality Act 2010.

1.4.9   Consider the need for independent advocacy if a person lives alone, has difficulty expressing their views and aspirations or lacks capacity.

Managing risk associated with missed or late visits

1.4.10   Home care workers should avoid missing visits. They should be aware that missing visits can have serious implications for people's health or wellbeing.

1.4.11   Closely monitor risks associated with missed or late visits and take prompt remedial action. Recognise that people living alone or those who lack capacity may be particularly vulnerable if visits are missed or late.

1.4.12   Ensure plans are in place for missed visits. These plans could include:

- making arrangements for a family member, carer or neighbour to visit

- giving home care workers contact details for this person

- setting out clearly in the person's risk assessment what should happen if a visit is missed.

1.4.13   Put contingency plans into action when visits are missed or late.

1.4.14   Ensure monitoring of missed and late visits is embedded in your quality assurance system and discussed at contract monitoring meetings.

1.4.15   Ensure home care workers contact the person who uses services (or their carer) if they will be late or unable to visit, as well as informing their manager, if appropriate.

Delivering telecare

1.4.16   Ensure that the telecare provider gives the person and their carer information about how to use the equipment, and confirm that the person can confidently use it.

1.4.17   Regularly review a person's use of telecare to ensure they find it useful. Involve the person in the review and seek feedback from others, such as carers or call centres. Keep the person informed about any new telecare options available.

1.4.18   Provide telecare call centres with all relevant information about a person's circumstances (if the person agrees).

1.4.19   If providing alarm-based telecare, ensure response systems are in place. For example, the alarm can be linked to a warden, live-in care worker, family member or contact centre.

1.4.20   If the alarm is set to alert a carer who does not live near the person, ensure there is a 24-hour, 7-days-a-week contact close by who is able to provide assistance.

1.5   Joint working between health and social care

1.5.1   Healthcare practitioners and home care workers should liaise regularly about the person's medication.

1.5.2   Healthcare practitioners should write information and guidance for home care workers about medicines in the home care plan.

1.5.3   Ensure health and social care practitioners working in primary and secondary care liaise with home care workers to provide integrated, person-centred support.

1.6   Ensuring safety and safeguarding people using home care services

1.6.1   Ensure there is a written process to follow in the event of a safeguarding concern and ensure that the process is aligned with local authority procedures. The process should include key contacts such as:

- emergency services

- the registered manager of the home care provider

- the local authority vulnerable adults or safeguarding helpline

- other sources of support, for example, the Care Quality Commission, Action on Elder Abuse, the local Healthwatch.

1.6.2   Ensure home care workers are aware of the process.

1.6.3   Build a culture in which reporting of safety and abuse concerns is understood as a marker of good care, not just as a negative outcome of poor care. Build such a culture by, for example:

- stating explicitly, as part of induction training, that safeguarding alerts are part of delivering a responsible home care service and that home care workers play a vital role in helping to safeguard a person using services, and

- providing case studies that demonstrate the far-reaching effects of not acting on safeguarding concerns.

1.6.4   Recognise that safeguarding alerts can be a responsible element of providing home care. Recognise that the home care worker may be the first person to spot abuse and neglect (including self-neglect) and should respond proportionately.

1.6.5   Put policies in place that ensure home care workers are supported through any safeguarding process.

1.6.6   Home care provider organisations should have a medicines management policy.

1.7   Recruiting, training and supporting home care workers

Recruiting and training home care workers

1.7.1   Have a transparent and fair recruitment and selection process that:

- uses values-based interviews and approaches to identify the personal attributes and attitudes essential for a caring and compassionate workforce, and

- ensures workers have the necessary language, literacy and numeracy skills to do the job.

1.7.2   Consider involving people who use home care and their carers in recruiting and training home care workers.

1.7.3   Ensure that new home care workers are observed at work more than once during their induction period.

1.7.4   Ensure home care workers are able to recognise and respond to:

- common conditions, such as dementia, diabetes, mental health and neurological conditions, physical and learning disabilities and sensory loss (see also recommendation 1.3.8 in the section on planning home care)

- common care needs, such as nutrition, hydration and issues related to overall skin integrity, and

- common support needs, such as dealing with bereavement and end-of-life, and

- deterioration in someone's health or circumstances.

1.7.5   Make provision for more specialist support to be available to people who need it (for example, in response to complex health conditions) either by training your own home care workers or by working with specialist organisations.

1.7.6   Ensure home care workers have the knowledge and skills needed to perform their duties safely by providing, as part of the full induction and ongoing training package, specific training on:

- what constitutes 'safe' care

- identifying and responding to possible or actual abuse or neglect

- identifying and responding to environmental risks

- safe care policies and procedures.

1.7.7   Use feedback from people using the service and their carers to assess training needs for the workforce.

1.7.8   Ensure home care workers have opportunities to refresh and develop

their knowledge and skills.

1.7.9 Develop workforce plans for the home care sector, in collaboration with provider organisations, identifying current and future workforce needs. Include training and how such needs might be met by prioritising available local authority resources in the plans.

Managing and supporting home care workers

1.7.10 Respond promptly to workers when they request support to deal with difficult situations.

1.7.11 Supervise workers in a timely, accessible and flexible way, at least every 3 months and ensure an agreed written record of supervision is given to the worker.

1.7.12 Observe workers' practice regularly, at least every 3 months, and identify their strengths and development needs.

1.7.13 Appraise workers' performance regularly and at least annually. The annual appraisal should include a review of workers' learning and development needs, and feedback from people who use the service and their carers.

1.7.14 Consider making training available for health and social care practitioners to ensure they collaborate to provide integrated planning and delivery of home care and support.

Terms used in this guideline

Home care plan

This is a written plan put together after the local authority assessment of overall need. It sets out the home care support that providers and the person have agreed will be put in place. It includes details of both personal care and practical support.

Named care coordinator

The named care coordinator is one of the people from among the group of workers providing care and support designated to take a coordinating role. This could be, for example, a social worker, practitioner working for a voluntary or community sector organisation, or lead nurse. Some aspects of this role may be undertaken by the person themselves, or their carer.

For other social care terms see the Think Local, Act Personal Care and Support Jargon Buster.

Recommendations for research

The Guideline Committee has made the following recommendations for research.

1 Intensity of home care packages

What is the effectiveness and cost effectiveness of different intensities of home care packages for older people with a range of care and support needs?

Why this is important

There is a lack of evidence on the cost effectiveness of different intensities of home care packages applicable to the UK. Additionally, the 2 included studies that consider the cost effectiveness of different intensities of home care only consider home care costs rather than wider resource use.

2 Telecare

What types of telecare are most effective and cost effective, when provided to older people as part of a package of home care?

Why this is important

There is limited evidence on the components of telecare used as part of a home care package for older people, and their impact. Information is needed on types of telecare in use, because costs and outcomes are likely to depend on the combination of components.

It would then be useful to compare different telecare packages and determine effectiveness and cost effectiveness of individual components and combinations of components. This could include comparisons with home care packages without telecare, or ones that include other assistive technology. Important outcomes for service users are social care-related quality of life and wellbeing, in addition to physical health, acceptability and accessibility (particularly for people with complex needs such as dementia). Cost information from a societal perspective is also needed, including health and social care services, the contribution of carers in the form of unpaid care and out-of-pocket expenditure for privately purchased support.

3 Training

What are the effects of different approaches to home care training on outcomes for people who use home care services?

Why this is important

Workforce training is perceived to help improve the delivery of home care services to both practitioners and people using the services. Reviews for this guideline found a lack of evidence on the impact of home care-specific training on outcomes for people using home care.

Studies of comparative design are needed to evaluate different approaches to home care training, and whether they change home care workers' practices in ways that improve outcomes for people and their carers, including safety and safeguarding. A scoping study is needed to identify the range and content of current training and ongoing support for home care workers, including specialist and generalist training. The outputs could inform future study design. Studies of qualitative design are needed to ascertain the views and perceptions of older people and their informal carers on worker competence. The views of commissioners and provider organisations on their experiences of training are also needed.

4 Specialist dementia support

What is the most effective and cost effective way to support people with dementia living at home?

Why this is important

Dementia is one of the most common conditions in older people using home care services. Home care workers are expected to respond to a wide range of needs, providing both general support (for example personal care) as well as specialist needs. Some home care is delivered by dementia-specific services but there is a lack of evidence about the effectiveness of this approach on outcomes compared with non-specialist home care services (which may instead employ specialist workers or train some workers to develop specialist skills, for example). Future research could involve comparative evaluation or case control studies to determine how to structure the delivery of support so that both a person's specialist dementia needs and general support requirements are accommodated

in the most effective way.

5 Safety and safeguarding

What safeguarding practices are most effective in improving outcomes for people using services?

Why it is important

The Guideline Committee identified variation in organisational attitudes to, and perceptions of, risk in both provider and commissioner organisations. The review found a lack of evidence on the impact of different safeguarding practices on organisational culture, service delivery and outcomes. Studies of comparative design are needed to evaluate the effectiveness of different approaches to safeguarding in maintaining safety and wellbeing of service users and their carers. Analysis of routine monitoring data, for example from service audits, could illustrate how standards are being met by providers. Surveys and qualitative studies are needed to ascertain the views of older people, and their experiences in respect of safety and safeguarding practice.

Home care implementation: getting started

This section highlights 3 areas of the home care guideline that could have a big impact on practice and be challenging to implement, along with the reasons why we are proposing change in these areas (given in the box at the start of each area). We identified these with the help of stakeholders and Guideline Committee members (see the section on supporting shared decision making in developing NICE guidelines: the manual). This section also gives information on resources to help with implementation.

The challenge: delivering services that support the aspirations, goals and priorities of the person

See recommendations 1.1.1 and 1.1.2 in the section on ensuring care is person centred.

Providing person-centred care helps deliver:

- better quality of life for people who use services and their carers; older people consistently value services that address their needs, choices and preferences

- greater job satisfaction for the workforce, because they are able to establish and develop relationships with people and support good outcomes for them as highlighted by the Skills for Care workforce development strategy.

Some services are still built on a 'one size fits all' model and changing this may be a complex process that can take time.

What can home care providers and commissioners do to help?

- Work together to review and negotiate contracts to ensure care is delivered flexibly. Identify whether improvements are needed to meet each person's needs and aspirations about how they want to live their lives. To do this, staff in local authorities, local home care managers and care staff can use this guideline, They can also draw on inspection reports of services rated 'outstanding' by the Care Quality Commission, NICE accredited Social Care Institute for Excellence (SCIE) guides and practice guidance about commissioning for better outcomes.

- Home care managers and workers can use this guideline together with good practice examples and tools from NICE accredited guides and endorsed products to reflect on their own current practice. These resources can support continuous learning and development about person-centred approaches.

- Ensure that people with cognitive impairment and those who live alone know about local community services that they can contribute to and get support from. These services include churches and faith groups, dementia cafes, befriending and volunteer schemes.

See tools and resources to help you to address these challenges and achieve best practice.

The challenge: working together to ensure care and support is coordinated

See recommendations in the section on coordinating home care and recommendations 1.3.22 and 1.3.24 in the section on access to and review of home care plans.

> Coordinated practice focused on the needs, preferences and experiences of the person can help deliver:
>
> - better health and care outcomes for people who use services
>
> - improved support for care workers
>
> - savings – because seamless care at home reduces overlap and duplication and staff can call on timely advice to maintain a person's wellbeing.

Good communication is essential to delivering good person-centred care and support. Care workers may feel unsupported in their role and anxious about the people they look after if they are not easily able to liaise with, or seek advice from, other practitioners. This can cause problems, for example, if they identify that a person's health or mental capacity is deteriorating or if they have concerns about medicines management.

What can commissioners and providers do to help?

- Develop protocols for multidisciplinary working to ensure that more social care and health practitioners collaborate effectively. Identify a care coordinator and ensure that they have a full understanding of their role and the knowledge and experience to carry it out.

- Establish the use of care diaries (or care records). Specify how all health and social care practitioners visiting the home might use the care diaries to record all care and support provided and to highlight the person's needs, preferences and experiences.

See tools and resources to help you to address these challenges and achieve best practice.

The challenge: strategic partnership working to deliver high quality and integrated home care

See recommendation 1.3.19 in the section on planning home care, and the section on contracting home care.

Partnership working leads to:

- improved outcomes for people using services when health, social care and voluntary sector managers work collaboratively and co-productively

- savings – because better provision of home care avoids the need for costly acute services.

When organisations do not work in partnership with one another to plan, organise and deliver services, there may be a negative impact on the wellbeing of people who rely on them. For example, people who have cognitive impairment, communication difficulties or sensory loss may feel an increased sense of social isolation if care workers do not have time to help them make connections with other sources of support in their local community.

What can commissioners, providers and voluntary sector and community organisations do to help?

- Use existing forums or create new opportunities to meet people who use services and carers to review the quality of services for people living at home. Existing forums that could be used include health and wellbeing boards, quality forums and provider alliances.

- Use this guideline to review what training about common health conditions is available for home care workers. Draw on examples of good person-centred practice to inform local health and wellbeing planning and help commissioning plans realise the intentions of the Care Act.

- Consider innovative approaches and services that can support people to maintain links with their family and local community. The SCIE guide on commissioning home care for older people includes some practice examples to stimulate ideas.

Need more help?

Further tools and resources are available from NICE that may help to support implementation. See also, the section on finding more information and committee details.

- Annual indicators for use in the Quality and Outcomes Framework (QOF) for the UK. See the NICE menu of indicators and indicator process guide.

- Uptake data about guideline recommendations and quality standard measures are available on the measuring the use of NICE guidance webpage.

Context

Home care is one of several services that can be offered to people assessed as needing social care support. It can be funded by health or social care commissioners or by the person using services. Although the range and type of services that can be classed as home care varies, it usually encompasses:

- personal care, for example help to wash

- support with the activities of daily living, which might also include telecare (for example providing personal alarms)

- essential domestic tasks.

Home care services may also help people to stay independent and take part in social and other activities.

A number of recent reports have identified significant concerns about the quality, reliability and consistency of home care services. A themed inspection of home care by the Care Quality Commission, Not just a number: Review of home care services, also highlighted some specific key areas for improvement.

The Department of Health asked NICE to develop a guideline to help address these issues (see the final scope). The guideline was developed by a Guideline Committee following a detailed review of the evidence on home care.

The Care Quality Commission uses NICE guidelines as evidence to inform the inspection process and NICE quality standards to inform ratings of good and outstanding.

This guideline focuses on older people receiving home care and their carers. The guideline does not cover younger adults (although many of the recommendations may also be relevant to younger adults). This is because the largest group of people using home care is older people.

This guideline considers how person-centred home care should be planned and delivered. It addresses how those responsible for managing, providing and commissioning home care should work together to deliver safe, high-quality home care services. These services should promote independence and support people to do the things that are important to

them.

This guideline has been developed in the context of a complex and rapidly evolving landscape of guidance and legislation, most notably the Care Act 2014. While the Care Act and other legislation describe what organisations must do, this guideline is focused on 'what works' in terms of how to fulfil those duties, and deliver support to older people using home care and their carers.

The guideline is for health and social care practitioners, home care provider organisations, home care managers, home care workers, commissioners of home care in local authorities and clinical commissioning groups, and people using or planning to use home care services.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic pages on older people, people with physical disabilities and multiple long term conditions.

For full details of the evidence and the guideline committee's discussions, see the full guideline. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

Minor changes since publication

March 2018: More details of relevant NICE guidance were added to recommendation 1.3.8, and reference to the Equality Act 2010 was added to recommendation 1.4.8.

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