Statement of Purpose

Residential Care Homes and Nursing Homes Act 1999 code of practice, Standard 25

Bermuda Health Council

2019 v1

|  |  |  |
| --- | --- | --- |
| **Contact information for Statement of Purpose:** | **Health Council**Mailing address:PO Box HM 3381Hamilton, HM PXStreet Address:Sterling House3rd Floor16 Wesley StreetHamilton, HM 11 | Email:healthcouncil@bhec.bmPhone:(441).292.6420 |
| **Overview:** | The Statement of Purpose is a requirement for all licensed care homes Standard 25 in the Code of Practice for Care Homes, issued under the authority of the Residential Care Homes and Nursing Homes Act 1999 and Regulations 2001. Changes to the Statement of purpose must be updated and resubmitted to Bermuda Health Council. Changes that require prior authorization must be sought before implementation.A draft Statement of Purpose is required as part of the licensing application process for residential care homes and nursing homes. |
|  |  |

Statement of Purpose for Care Homes

March 2019

|  |
| --- |
| Operator’s Information- The Operator is the person or entity applying for or issued a care home license under section x of the Residential Care home and Nursing Homes Act 1999. |
| Full name |       |
| Legal status | Sole proprietorship | [ ]  | Incorporated | [ ]  | Charity | [ ]  |  |

|  |
| --- |
| 2. Operator’s address, including for service of notices and other documents |
| Business address2 |       |
| Business telephone |       |
| Electronic mail (email)3 |       |

|  |
| --- |
| 3. The full names of all the partners or Board members |
| Names: |       |

By submitting this statement of purpose you are confirming BHeC to use the **email address**. Email ensures fast and efficient delivery of important information. Notifications issued under the Residential Care Homes and Nursing Homes Act 1999.

The information contained in this Statement of Purpose will be held in confidence by the Government of Bermuda. Any sharing of information by the Ministry of Health of this information with another government department or government agency is for regulatory purposes or data collection.

|  |
| --- |
| **Care Home Location** |
| **Address** |       |
| **Telephone** |       |
| **Email** |       |

|  |
| --- |
| **Description of the location**(The premises including room numbers and descriptions, the surrounding area, access, adaptations, equipment, facilities, suitability for relevant special needs) |
|       |

|  |  |
| --- | --- |
| **No of residents** |       |
| **No of respite beds** |       |
| **No of day care attendees** |       |

|  |
| --- |
| **Care recipients served by the care home** |
| Adults aged 18-65 | [ ]  | Adults aged 65+ | [ ]  |  |
| Mental health | [ ]  | Sensory impairment | [ ]  |  |
| Physical disability | [ ]  | Intellectual disabilities | [ ]  |  |
| Dementia | [ ]  | People who misuse drugs or alcohol | [ ]  |  |
| Other:       |

|  |
| --- |
| **Aims and Objectives**(Describe the aims and objectives of your care home and the services you provide the care recipients) |
|       |

|  |
| --- |
| **The service type(s) provided at your care home-**  |
| Independent living services- no part of care home houses persons requiring support with household tasks but no direct care or supervision. | [ ]  |
| Personal Care services- supervision, support and direct care for daily care tasks | [ ]  |
| Personal Care Nursing Services- RN onsite less than 4 hours per day | [ ]  |
| Intermediate Care Nursing Services- RN onsite less than 12 hours per day | [ ]  |
| Complex Care Nursing Services- RN onsite 24 hours per day | [ ]  |
| Hospice services  | [ ]  |
| Rehabilitation services  | [ ]  |
| Specialized care services\* (e.g. Dementia, intellectual disabilities, mental health)List:  | [ ]  |
| Doctor consultation and treatment services | [ ]  |
| Dental service  | [ ]  |
| Other:  |
| **Activities Program** –Describe: Type, frequency, approach?) |
|  |

\* Care staff have certification in the specialized area and the home’s philosophy, design and practices align with an appropriate care program.

|  |
| --- |
| **Staffing**  |
| **Management**  |
| Administrator | Name: | Deputy Administrator | Name:  |
| Qualifications: | Qualifications: |
| Accountant: |  |
| Other: |  |
| **Care Staff:** total number onsite; hours per day; days/wk |
| Registered Nurse | [ ]  | 1; 2hrs/day; 5days/wk | Nursing Associates | [ ]  | 2;24hrs/day;7 |
| Medical Consultant | [ ]  |  | Activities Coordinator | [ ]  |  |
| Rehabilitation (OT/PT/SLP) | [ ]  |  | Caregivers | [ ]  |  |
| Cook | [ ]  |  | Food service | [ ]  |  |
| Other: |

|  |
| --- |
| **Policies and Procedures –** tick the ones you have and submit copies with the Statement of Purpose |
| Admission, discharge and care coordination  | [ ]  |
| Confidentiality | [ ]  |
| Complaints handling and suggestions  |  [ ]   |
| Food and Nutrition services |  |
| Protection, detection and reporting of abuse |  [ ]   |
| Managing Challenging Behaviors Use of restraints and restrictive practices  | [ ]  |
| Mandatory reporting and handling of incidents  | [ ]  |
| Best practice clinical guidelines for common conditions in the care home  | [ ]  |
| Medication administration, management, storage and disposal  | [ ]  |
| End of life and post death care | [ ]  |
|  |  |
| Other: |  |
| Care recipient service guide |  |
|  |  |
|  |  |
|  |  |
|  |  |