Independent Whole Systems Review

into Safeguarding and Care at Dunmurry Manor Care Home

EVIDENCE PAPER: 1

Adult Safeguarding

within a Human Rights Based Framework

in Northern Ireland

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cpea Adult Social Care and Health Management Associates

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Section A: Introduction

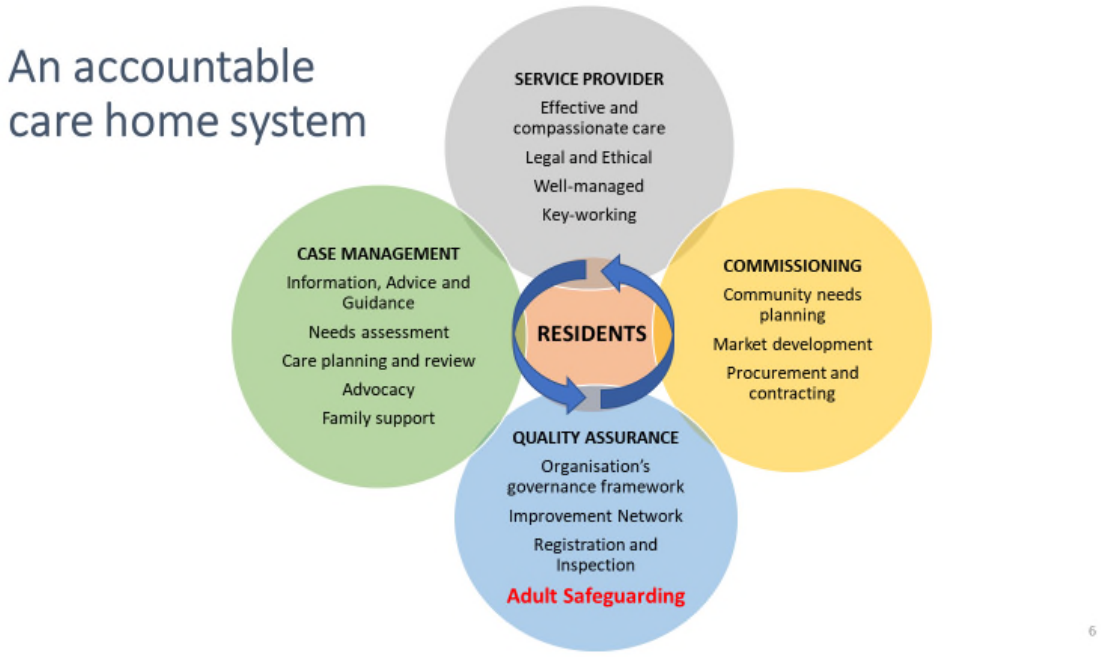
1. The Department of Health ("DH") of the Northern Ireland government commissioned CPEA Ltd ("CPEA") to undertake a *whole systems* review following the safeguarding and care issues identified by the Commissioner for Older People for Northern Ireland's ("COPNI") investigation into Dunmurry Manor Care Home ("DMCH")[1] which is run by Runwood Homes Limited ("Runwood").
2. Families had approached COPNI to express significant misgivings about the standards of care at the home. They reported that the care provider, the Regulation and Quality Improvement Authority ("RQIA"), the Health and Social Care Trusts ("HSCTs") and the Patient and Client Council ("PCC") had not addressed their complaints and they had nowhere else to go. In response, the COPNI used his investigation powers for the first time, requiring the DH, the HSCTs, RQIA and Runwood to submit information for his consideration. He engaged an expert panel of three[2] to advise him.
3. *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home* ["Home Truths"] was published in June 2018. It is critical of the practice of adult safeguarding[3] and asserts the case for safeguarding legislation.[4]
4. The purpose of the whole systems review is to learn and change. An Evidence Paper is a way of soliciting comment to inform and advise those who are responsible for formulating and implementing change. The sources of adult safeguarding data and information are documented in Appendix A. This Evidence Paper addresses the question of what adult safeguarding achieved for the residents of DMCH and considers the broader impact of safeguarding initiatives on adults in residential and nursing settings in Northern Ireland. It draws on the experiences of the families of older people and professionals across health and social care; re-visits the information shared with the COPNI in the light of NI's safeguarding policy, procedures and associated processes such as contract monitoring; and it references peer-reviewed articles concerning the harms experienced by older people in residential settings and the ways in which the likelihood of such harms occurring may be reduced. Finally, its "proposed actions" arise from discussions among the Review Team, versions of which have been explored with families and professionals. It is brought forward in advance of the full report of the whole systems review as part of the DH commitment to make change and enhance the safety of people known to services.
5. The position of adult safeguarding in the context of the whole systems review is shown in the graphic below.

[1] It has been renamed Oak Tree Manor by Runwood Homes Ltd. For the purposes of the *whole systems review,* the name DMCH has been retained

[2] Eleanor Hayes, with expertise in nursing and care; Professor John Williams and Dr Robert Peat with expertise in safeguarding and human rights; regulation, inspection and commissioning respectively.

[3] This paper concerns adult safeguarding, *Home Truths* was critical of the standards of care at DMCH and of the whole system around care homes.

[4] Claire Keatinge, the first COPNI, published a Briefing Note in June 2014, *Protecting Our Older People: A Call for Adult Safeguarding Legislation.*



6. The Structure of the Evidence Paper reflects the endeavours of the Review Team to find meaning in the different configurations of adult safeguarding information. Counting referrals about different types of abuse – psychological, sexual, physical for example - reveals little about the volume entered into the safeguarding system or the inconsistencies in recording and practice within and across HSCTs. Of more use is information about the setting in which an individual is harmed – most particularly if the nature of the relationship between the person who is harmed and the person alleged to be responsible is known. Qualitative information is typically required to understand the context so it was engagement with professionals and the relatives of the people living in care homes that helped shape this Evidence Paper's structure. It begins by setting out the background to the review and the factors shaping a "good life" in care homes and leads to an exploration of the term "adult safeguarding" and Northern Ireland's policy and procedures.
7. In this and following sections, illustrative quotations from interviews and discussions during adult safeguarding workshop/events as well as meetings with individuals, families and groups are presented. The contributions of professionals delivering care and support to older people have been invaluable in analysing the challenges inherent in adult safeguarding practice and exploring with the Review Team what actions may be taken to improve practice. The main body of the Evidence Paper considers how adult safeguarding and associated activities work. Starting with the findings of *Home Truths,* it presents adult safeguarding information from the HSCTs for the purposes of the investigation and from the DH's audit of adult safeguarding.[5] The methods used gave assurance that as the experience of individuals was shared, their

[5] An audit of safeguarding investigations in relation to care homes operated by the independent sector was ordered by the Permanent Secretary on 27th June 2018. See: https://www.health-ni.gov.uk/news/department-health-details-series-measures-care-home-standards (accessed 1st July 2018)

identities and those of their families would be protected. In upholding those assurances, steps have been taken to convey relevant matters without personal, identifiable information.

8. Since residents' families have a compelling track record in specifying what needs to change in terms of fulfilling the support needs of their relatives, an overview of the themes they identified is presented. The realities faced by the HSCTs in invoking procedures are reported, followed by a consideration of "quality" and relevant notifications[6] to the RQIA. The penultimate section concerns partnerships in adult safeguarding and the remits of different organisations. The final section is a reality check because it does not appear that people are being made consistently safer by adult safeguarding practices in Northern Ireland.
9. Throughout the Evidence Paper, sections are concluded with "POINTS TO CONSIDER." These reflect the Review Team's discussions about emergent learning and possibilities for change as well as discussions with contributors – both professional and non-professional. They reflect the "no surprises" approach of the Review Team. The process of identifying them has helped to clarify our thinking and has shaped the specific advice and proposals within the final section of this paper.
10. There are several actions that ought to be taken and can be initiated without waiting for the perfect solution or the right time. The events at DMCH confirm the critical need for decisive action in protecting residents from actual and possible harm and neglect. This should not be separate from the tasks of seeking to understand the factors which led to harm. Actions should be concurrent, focussed on the resident(s) concerned and attentive to the importance of residents controlling those aspects of their lives that remain within their gift. Actions must be do-able and demonstrably add benefit to people's lives. They must be proportionate, risk-benefit based and credible.

[6] Regulation 30, among other things, requires notification to RQIA of 'any event in the home which adversely affects the care, health, welfare or safety of any resident/ any event in the nursing home which adversely affects the wellbeing or safety of any patient'.

Section B: Context

Strategic Background

11. During 2010, the strategic responsibility for adult safeguarding was delegated to the Health and Social Care Board ("HSCB") by the DH. The operational responsibilities for adult safeguarding are held by five HSCTs – Belfast HSCT, South Eastern HSCT, Western HSCT, Southern HSCT and Northern HSCT. Each manage and administer hospitals, health centres, residential homes and day centres and provide a range of health and social care services to the community. (A sixth HSCT is the Northern Ireland Ambulance Service ("NIAS") which operates a single, region-wide service). The "Northern Ireland Adult Safeguarding Partnership ("NIASP") and five Local Adult Safeguarding Partnerships ("LASPs") were established under *Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements* (Northern Ireland Office and DHSSPS 2010). The LASPs report to the NIASP which reports to the HSCB (via the Chair who is a senior officer), which reports to the DH.
12. DMCH is in South Eastern HSCT ("SEHSCT") area which acts as 'host' HSCT. At the time of the COPNI investigation there were residents at DMCH from all HSCTs except for Western HSCT.

Residents and Families

13. Discussions with the relatives of people who had lived at DMCH and at other homes in NI were occasions to reminisce about the lives of the people they loved. They affirmed that the lives of their relatives mattered a great deal before and after the decision was made to leave their own homes and move into a care home. They shared the distress and difficulties experienced in making these decisions. Some families have experienced relationship breakdowns with continuing impacts on their lives.
14. Although the background to people's transitions into care homes was diverse, the shared themes included decisions made by acute hospital clinicians and GPs; families acknowledging suspicions that their relatives' behaviours were becoming atypical and/or their memory loss more noticeable; a diagnosis of dementia, falls at home, and/or compromised health status; the death of spouses whose day to day support had disguised the extent of support required by their partners; and, reluctant acknowledgement that the support of relatives and friends could not keep pace with a person's accelerating need for help.
15. Typically, families had no previous experience of the care home system, struggled to make sense of the terminology of care and regulation and reported that the lack of clear, easily accessible information made "the system" even harder to understand. The relocation of their relatives was stressful, most particularly if it was associated with feelings of guilt and distress. Involvement in the post-placement lives of older people included investing in continuing relationships with spouses, siblings, children and grandchildren. However, not everyone recalled welcoming admission processes or even engaging communication with families. When DMCH families became attuned to evidence that their relatives were unprotected, that their care needs were overlooked and their appearance deteriorated, they questioned the adequacy, competence, empathy and continuity of care staff and their managers.

Living in a Care Home within a Human Rights Based Framework

After all, "…What good is it making someone safer if it merely makes them miserable?" [7]

"Human rights principles emphasise the importance of achieving a balance between ensuring residents' safety and promoting independence" [8]

16. Care homes are a critical and conspicuous part of the UK's care infrastructure and are likely to remain so. As Kennedy[9] noted:

> "Care homes can be good places. They can be safe, secure and stimulating places to live and work, capable of fostering good relationships between people living and working in them and wider communities…Around 400,000 older people in the UK live in care homes, cared for by over a million care workers, 24 hours a day, seven days a week. With an ever-increasing population of older people, getting care homes 'right' is crucial to ensure a 'good life' for ALL of us – our parents and grandparents, aunties and uncles, friends and neighbours and, not least, ourselves!" (p10-11)

17. For people who are moving into care homes on a permanent basis, factors which shape a "good life" include sustaining relationships with families and friends and developing positive relationships with support staff. As well as recognising the significance of people's relationships inside and outside the care home, understanding what matters to individuals and helping them to maintain their independence and sense of self in their daily lives are critical. The potential for families to play a significant part in caregiving should be understood and welcomed.
18. Care homes are synonymous with group living. New residents and their families may not appreciate that the person-to-person care and support provided to individual residents is time-limited. Furthermore, maintaining mobility and being able to negotiate ways around care homes are important skills. They entail acceptance that the possible consequences of being mobile may be beneficial *or* harmful. This means that care homes typically support older people to take risks. The 'risk management approach' of care and support in a care home

[7] "A great judge once said, "all life is an experiment," adding that "every year if not every day we have to wager our salvation upon some prophecy based upon imperfect knowledge" (see Holmes J in Abrams v United States (1919) 250 US 616 at pages 624, 630). The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else. Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?" Munby J (as he then was) in Local Authority X v MM & Anor (No. 1) (2007)

[8] Page 66 of Northern Ireland Human Rights Commission (2012) *In Defence of Dignity - the Human Rights of Older People Living in Nursing Homes* Belfast: NIHRC, March

[9] Kennedy J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

involves identifying what needs to be in place to make it more likely that the benefits will be enhanced and harms reduced. However, there can be no guarantees of absolute safety.

19. The Registered Manager of a care home provides the leadership and management within a context of regulation and minimum standards as set by DH. (Many family members expressed dismay at the concept of minimum standards that did not reflect their expectations of care.) Registered Managers undertake this through values-based and relationship-based approaches to "caring well," that is, without detriment to individuals. This includes encouraging and supporting older people to maintain some control around their personal routines and activities, in making choices and in exercising their rights.
20. Just as with the general population, keeping care home residents safe requires environments and systems that seek to prevent harm as well as to respond to it in the most beneficial way. These tasks accept that taking reasonable risks can lead to accidents and mistakes, albeit permitted, for positive, documented reasons.
21. It is against this backdrop that when difficulties emerge in the life of a care home – such as those at DMCH - providers and managers must be accountable. Their powers and duties within legal and regulatory frameworks are centre stage in terms of accountability. The latter concerns trust, that is, trusting that all employees, managers and the regulator will hold people to account for the problems for which they are responsible, take improvement actions and contribute to learning. At best, accountability is not solely backward-looking, it is also forward-looking.[10]
22. *The Senses Framework: Improving Care for Older People through a Relationship-Centred Approach* [11] - identifies one of the six Senses within the framework as *Security - feeling safe. That is, ensuring that the person you care for: is safe and free from threat, harm, pain or discomfort…receives competent, sensitive and consistent care…is able to make choices about what they do.* The other Senses concern continuity, belonging, purpose, achievement and significance.
23. The *My Home Life*[12] initiative draws from the *Senses Framework* and underlines the rights of older people to retain their personal agency, dignity and control regardless of their age and health status. It identifies eight "Best Practice Themes," one of which is *Sharing Decision-making: Facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life*. Other themes concern maintaining identity; creating community; managing transitions; improving health and healthcare; supporting good end of life; keeping the workforce fit for purpose; [and] promoting a positive

[10] Dekker, S. (2012) *Just Culture: Balancing Safety and Accountability* 2nd Edition, London: CRC Press, An Ashgate Book

[11] *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice* (GRiP) Report No 2. Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. Available from Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/280/; (accessed 4th September 2019)
Nolan, M. Lundh, U., Grant, G. and Keady, J. (Eds.) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press McGraw-Hill Education, 2003

[12] See https://www.myhomelifeni.co.uk/ (accessed 16th July 2019)

culture. During a discussion, the Responsible Individual[13] at Runwood advised the Review Team that the company's Registered Managers in Northern Ireland who had completed the *My Home Life* Leadership Programme included those at Weaver's House, Orchard Lodge Care Home and Kintullagh Care Home, for example. [14]

24. The events that precede an older person's admission to a care home are likely to be characterised by distress, most particularly if this major life event is triggered by a crisis. For many families it may be the first time that they encounter social care services, care homes, HSCTs and Care Managers. They are unlikely to have the information, knowledge or understanding about what to expect, what to do or who to ask questions with regard to attention to their relatives' support needs, for example. Many older people want and need their families to act on their behalf and to maintain a relationship with them, albeit in the face of uncertainties. People's families are more than visitors. Being part of a family and amongst staff and communities are critical to people's emotional well-being and their "sense of continuity." There is little evidence to suggest that families experienced such an approach at DMCH.
25. Care homes are subject to considerable scrutiny, most particularly when accidents happen and mistakes are made. Sometimes accidents and mistakes cause harm and sometimes they do not. Judgement and balance are important features of leadership across the care home system so that the danger of becoming "risk averse" is challenged and remedied wherever it occurs. Safeguarding systems may not be the best means of tackling every harmful caregiving scenario in all settings. Adult safeguarding applies methods which are most suited to addressing an individual's circumstances rather than those of group living/communal settings. The risks may result from people living together, some of whom may not be compatible with others and/or placed in circumstances or in areas within homes that become unsafe.
26. Necessarily people must be safe in care settings but it is unlikely that every accident, mistake or evidence of inattentive care reaches the point at which adult safeguarding is or should be invoked. What is the case for bringing the full weight of multi-agency, multi-professional activity to bear on a home – typically in an uncoordinated manner – when many situations require action by the manager, that is, complaints' investigations, adherence to contracts and regulations or referring to the Police Service of Northern Ireland ("PSNI") for investigation?
27. Most families believe that if their complaints concerning DMCH had been promptly addressed within a reasonable timeframe, the volume of safeguarding referrals could have been avoided and there would have been no need for the COPNI investigation.
28. The Human Rights Commission's investigation of nursing homes considered residents' quality of life, personal care, eating and drinking, medication and health care and the use of restraint. It stated that, *the same human rights apply to all regardless, even if the application of those*

[13] Responsible Individuals are in charge of overseeing the management of services regulated by RQIA and are ultimately accountable for safeguarding and promoting the welfare of vulnerable people in their care. They should have knowledge of and commitment to good care practices and possess the competencies necessary for the management of the service. Honesty, integrity and trustworthiness are essential requirements in determining the suitability of an applicant for registration.

[14] It is understood that a Regional Quality Manager became a mentor/ facilitator for *My Home Life*

standards requires different actions from the duty bearers (p10).[15] The report focused on how the quality of life of older people with complex health needs may be advanced. It proposed that the failure to place human rights standards at the core of nursing homes' legal and regulatory framework undermined residents' human rights. The report is silent about an adult safeguarding response to breaches of residents' human rights.

29. The report recommended clarity concerning human rights' standards and proposed that they should be applied by:
    - recognising the individual in a personalised way and supporting them;
    - encouraging and enabling older people to spend their days as they wish;
    - being involved in how personal care is provided;
    - being involved in when medication and treatment are provided; and
    - affording dignity and human rights protection.
30. The significant contextual background to DMCH and care homes generally was (i) the Human Rights Commission's primary focus: the right to life, to security, to respect and to "procedural protection in the event of a need for restraint" and (ii) the COPNI's advice to the Minister for Health, Social Services and Public Safety about changing the culture of care provision in Northern Ireland.[16]

POINTS TO CONSIDER – Learning and Change

- ✓ The assessment and support of risk decisions is not conspicuous in the safeguarding documentation concerning DMCH. A regional approach to risk management is required.
- ✓ Registered Managers' knowledge of the law and regulations is taken for granted rather than being the subject of planned training.
- ✓ The experience of residents and families when accidents happen, mistakes occur or when someone is harmed reveals a great deal about a home's leadership and readiness to improve practice. Responses to complaints must demonstrate timely remedy.
- ✓ The *My Home Life* leadership programme is experienced in seeking to promote a positive culture in care homes.
- ✓ Since some DMCH residents experienced safeguarding incidents soon after their admission, steps to encourage and promote a *sense of security* and *continuity* are needed at the outset.
- ✓ There is a case for setting out the specific contribution of adult safeguarding to features of communal living.
- ✓ Northern Ireland's care homes are expected to adopt a values-based approach. How this is advancing residents' human rights should be made explicit.

[15] Northern Ireland Human Rights Commission (2012) *In Defence of Dignity - the Human Rights of Older People Living in Nursing Homes* Belfast: NIHRC

[16] Commissioner for Older People for Northern Ireland (2014) *Changing the culture of care provision in Northern Ireland* Belfast: COPNI https://www.copni.org/media/1122/changing_the_culture_of_care_provision_in_northern_ireland_pdf.pdf (accessed 1st June 2019)

What is meant by Adult Safeguarding?

> "Families and service users need to understand us/the language we use and the processes" – contributor to the Adult Safeguarding Workshop - 12 March 2019

31. Confusion existed among families with relatives at DMCH about what adult safeguarding means.[17] Its language is bewildering. Families reported feeling anxious and concerned, perhaps interpreting "safeguarding" as being about the risk of violence and "just didn't know how to respond to do the right thing." The language of safeguarding typically matches that which is set out in policies and procedures and it explains as well as obscures. "Safeguarding" is not readily understood. In contrast, families understand terms such as "keeping people safe" and "adult protection."
32. The Introduction to *Adult Safeguarding: Prevention and Protection in Partnership* (DH and DoJ, 2015) states:
    Within this policy the term 'safeguarding' is used in its widest sense, that is, to encompass both activity which prevents harm from occurring in the first place and activity which protects adults at risk where harm has occurred or is likely to occur without intervention (p4).
    The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult' **…***This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood…Preventive Safeguarding includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur* (p5).
    Protective Safeguarding will be targeted at adults who are in need of protection, that is, when harm from abuse, exploitation or neglect is suspected, has occurred or is likely to occur (p6).
33. The safeguarding lexicon is too remote from everyday language. For example, some of the following terms merit space in a glossary: *threshold of assessment of need/risk… Adult Protection Gateway Service… protection plan… Threshold for Protection/screening… harm… serious harm… Multi Agency Risk Assessment Conference… Strategy Discussion… Monitoring/review… alternative safeguarding responses… investigation… untoward/adverse incidents... Designated Adult Protection Officer* ("DAPO").
34. Similarly the following statement which features in Appendix 10 of the *Protocol for Joint Investigation of Adult Safeguarding Cases,*[18] requires explanation. *The criteria for NOT reporting to PSNI are met and Apply Regional Adult Safeguarding Policy and Procedures for single Agency – manage under HSC Trust Procedures.*
35. The terms "concerns" and "complaints" feature in the safeguarding vocabulary of the HSCTs. There is an unclear interface between them. "Concerns" are non-specific and barely capture the harms endured by some residents. Families were clear that they initially raised 'concerns' about the physical condition of their relatives and their rooms. For example, they alerted the

[17] This confusion was not unique to families with relatives at DMCH
[18] NIASP August 2016

home to residents' deteriorating/ unkempt appearance and to food trays being left untouched in their rooms. When no changes occurred they made complaints. Because DMCH was unresponsive to families' complaints, the Review Team learned that the circumstances of their relatives and those of other residents continued to deteriorate.

36. The increasingly abstract entity of safeguarding requires attention because of its lack of clarity. For example, restating and refining definitions and operational policies within the HSCTs concerning, *physical abuse…sexual violence and abuse…psychological/emotional abuse financial abuse…institutional abuse...neglect…exploitation…domestic violence and abuse…human trafficking…*and *hate crime* (p13-15), do not provide practitioners with the means to deal with complex scenarios. As professionals noted in relation to DMCH, "You have to report any incident. Everything gets reported or you get blamed and all our time is spent just reporting things that don't need to be, just so we can cover our backs. // It's asking [the practitioner] to establish whether the threshold of harm has been met in which case you go down the adult safeguarding route and if it is serious harm, then it's the adult protection route."

POINTS TO CONSIDER – Learning and Change

- ✓ The model of safeguarding as set out in NI's policy and procedures is far-reaching and without decisive limits.
- ✓ The terms "roles" and "responsibilities" were used in all meetings. Arguably information concerning the remit and legal powers of professionals and the resources of their organisations is more useful than lengthy lists of their roles and responsibilities. Since the remit and legal powers of the HSCB, the HSCTs, NIASP, LASPs, the RQIA, the Northern Ireland Public Services Ombudsman ("NIPSO"), the PSNI, the Coroners Service which is part of the Northern Ireland Courts and Tribunal Service ("NICTS") and the Health and Safety Executive Northern Ireland ("HSENI") are not set out in this policy, there is uncertainty among practitioners about which professionals should assume lead responsibility within and across all sectors.
- ✓ There is confusion about what to report and how the reporting requirements, including escalation, to the host HSCT, the funding HSCT and the RQIA, work together.
- ✓ The culture within which safeguarding is operating has resulted in the "risk averse" practice of reporting everything.

Policy and Procedures

> "When they said that Mum was now in safeguarding, I was frightened, didn't understand it and thought she had been attacked" – relative of a DMCH resident
>
> "Safeguarding is put before caring for people"- relative of a DMCH resident

37. The adult safeguarding policy framework for Northern Ireland was set out by the DH[19] and DoJ in 2006. The *Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance* defined a vulnerable adult as:
A person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility; by reason of mental or other disability; age or illness; 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.
38. This policy was revised, updated and published during July 2015. On publication, the Health Minister stated: *The policy provides the framework within which social workers, social care providers, health care providers, PSNI officers and those involved in the community, can work to prevent harm to adults at risk, recognise it and respond to it when it happens, and help those affected obtain the justice they deserve*.[20]
39. The aims of the policy *Adult Safeguarding: Prevention and Protection in Partnership* are to:
    - *promote zero-tolerance of harm to all adults from abuse, exploitation or neglect;*
    - *influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life;*
    - *prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion;*
    - *encourage organisations to work collaboratively across sectors and on an interagency and multi-disciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring;*
    - *establish clear guidance for reporting concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be responded to;*
    - *promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect;*
    - *promote a continuous learning approach to adult safeguarding* (p7).
40. In the 2015 policy,
An 'Adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their: a) personal characteristics AND/OR b) life circumstances.

[19] Until 9 May 2016, the DH was known as the Department of Health, Social Services and Public Safety.
[20] DH Press Release *Adult safeguarding policy for Northern Ireland* was published on 10 July 2015

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

An 'Adult in need of protection' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their: a) personal characteristics AND/OR b) life circumstances AND c) who is unable to protect their own well-being, property, assets, rights or other interests; AND d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed (p10).

41. The 2015 policy ceases to focus on vulnerability. It depicts adult safeguarding as a continuum from prevention to protection. That is, the 'safeguarding response' to adults at risk is twofold:
    - 'targeted services' (including statutory, voluntary, community, independent and faith organisations) and
    - 'protection services' which are led by HSCTs' social workers and/or the PSNI.
42. However, the continuum depicts two thresholds. One for the "assessment of need/risk" to distinguish "a person aged 18 or over" and an "adult at risk of harm." The "threshold for protection screening" distinguishes an "adult at risk of harm" and an "adult in need of protection." In addition, there is *harm…the impact on the victim of abuse, exploitation or neglect" and "serious harm…a number of 'small' incidents may accumulate into 'serious harm' against one individual, or reveal persistent or recurring harm perpetrated against many individuals…there are no absolute criteria for judging when 'harm' has become 'serious harm'* (p11-12).
43. The principles underpinning the 2015 policy are fivefold: *a rights-based approach… an empowering approach… a person-centred approach… a consent-driven approach… a collaborative approach* (p8-9).
44. The policy omits to reference the relevant legislation and Orders which influence safeguarding in NI. (See Appendix B: The legislative architecture.)
45. The policy states that: *Robust governance arrangements are key to an organisation's ability to keep adults safe from harm… Both internal governance and external measures are vital to ensure that safeguarding concerns are identified early and escalated to enable appropriate action to be taken* (p23). Examples of "internal governance" include *robust selection and recruitment procedures… effective management… procedures for responding to… safeguarding concerns… procedures for cooperating within the organisation and with others as required to address safeguarding concerns… procedures for managing… complaints… records… the sharing of information* (p24-25).
46. "External governance" is a free-standing section of the policy and it notes that *Services for adults at risk may be commissioned or subcontracted by a range of organisations across the statutory, voluntary, community, independent or faith sectors…*e.g. *the NIHE* [Northern Ireland Housing Executive], *local councils, PSNI and other justice organisations or the HSC sector…The HSCB, HSC Trusts and the PHA* ("Public Health Agency") (p27). The section advises that in relation to the management and monitoring of contracts, all commissioning

organisations, should be knowledgeable about adult safeguarding, meet the requirements as set out in the policy, *monitor the performance of service providers and identify any deterioration in standards of care and risks this may present; regularly audit the third party service provider…escalate any concerns about the provision of care to the care manager/key worker or senior management and where requirements are not being met, to use appropriate reporting mechanisms to ensure adults at risk are kept safe, and where necessary, impose appropriate sanctions* (p27).

47. The following observations were made by senior HSCT managers at an event during July 2019: "If you trace back to 2015, the policy was flawed. // It was a flabby policy. // Adult safeguarding has corrupted social work. // The intention of the policy was not translated into practice. //There's no clarity at a system level. // We refer matters to the RQIA and they put responsibility back to the Trusts. // There's confusion across the system. // It's timely to review the processes in layman's terms. // There are massive inconsistencies between the regional policy and the procedures. // Quality of care matters have different processes to safeguarding. // It's "everyone's business" but no one adds, it's about needs assessments and risk assessments. // Adult safeguarding covers everything and it shouldn't. It hasn't got the thresholds right in relation to protection. // The policy has driven confusion – it's out of date. // It's not fit for purpose. It needs more work. // Our work should be about helping people to live in a safe way. // It was as though when we heard "abuse" we jumped. // The policy isn't geared towards people in permanent care. // Policy development should be organic but there was little listening and no account taken of feedback. // There were opportunities to be involved in developing it. // The policy isn't right and neither is the way it is implemented – the policy and procedures are chalk and cheese with no synergy. // There were different authors."
48. With reference to all professionals with responsibility for carrying out the care management process and function, the policy states that they *must* focus on individuals, for example,
    - *Ensure that needs and risks to the adult at risk are identified and assessed, taking account of their views and preferences*
    - *Ensure that there is a personalised care plan detailing the needs of the adult…*
    - *Ensure the care plan is being implemented…reviewed regularly…* [and that] *they are informed of any incidents, accidents or near misses in respect of the individuals for whom they have commissioned care* (p28).
49. The policy also requires Care Managers to take on a wider brief of ensuring, for example:
    - *That a safe and high-quality service is provided, noting any patterns emerging and which suggest there may be a cause for concern and acting upon any concerns*
    - *That they are informed of any complaints made and action taken to address them*
    - [an analysis of] *trends to identify patterns which may indicate low level concerns or poor-quality care issues which may accumulate to indicate that there is a risk of harm*
    - [That they] *escalate concerns which may indicate serious harm or risk of serious harm to an adult at risk* (p28).
50. The policy describes: "The Role of Regulation and Quality Improvement Authority" as having:

…a key preventative role in adult safeguarding practice…a responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect…Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance…care governance elements…the number, nature and outcome of complaints made; safeguarding concerns raised with the Adult Safeguarding Champions; notifiable incidents or accidents which occurred…any disciplinary procedures conducted (p30).

51. RQIA's information sources include care homes' complaints records, notifiable incidents and accidents which, *should be triangulated* with a view to setting out trends for example. It *will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI and will be a key partner to contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service* (p31).
52. RQIA wrote a briefing paper for the DH on 15 June 2018. This noted:
"The 2015 Safeguarding Policy clearly establishes the HSCTs as the primary investigators of safeguarding incidents. It is correct that there is a crossover between safeguarding and care failures. Allegations of institutional abuse, neglect and failures to maintain human rights are all clear safeguarding issues. The [COPNI] *report cites numerous examples where HSCT staff have found care failings in the home. It is not clear what action the HSCT staff then took. These professional staff all operate under codes of conduct which include duties of care and candour…"*
53. The CE of RQIA referred to paragraph 14.3 of the policy in correspondence of 9 February 2018 to the HSCTs:
"I believe the RQIA and Trusts could and should be working more effectively to share information on trends identified in individual homes or groups of homes and would like to discuss with you how best to formalise this. RQIA cannot analyse every incident…but intelligence on trends would be very useful in planning inspections. I am aware that Trusts report at a strategic level to the HSCB as part of the Delegated Statutory Functions return and whilst there is some value in this for RQIA, it is not detailed enough for our purposes. I am aware of the responsibility noted in the safeguarding policy on those who monitor and manage contracts "to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract" (9.1) …these audits would be a valuable source of intelligence to RQIA. As a first step, I would be grateful if you could provide copies of audits and quality monitoring reports[21] *undertaken in respect of all Runwood homes since October 2016…time constraints mean that inspectors are unable to attend all such* [safeguarding] *meetings, I am keen that they understand and take the opportunity to learn*

[21] The Health and Personal Social Services (NI) Order 2003 states [34(1)] Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of – (a) the health and personal social services **which it provides to individuals** [emphasis added] (b) the environment in which it provides them.

from and share knowledge with Trust colleagues when there is a sense that issues are escalating within a home…"

54. The policy ends with a high-level overview of the topics of "Consent and Capacity," "Access to Justice," "Information Management/Sharing," safeguarding training and learning.
55. The September 2016, *Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection* were written by NIASP. As the 2015 policy noted: *The HSCB's regional operational adult protection procedures will underpin this policy and provide guidance to support good practice and sound professional decision-making. Procedures will be subject to regular review* (p42).
56. The Introduction of the Operational Procedures advised, "they should be read in conjunction with" the 2015 policy and the August 2016 *Protocol for Joint Investigation of Adult Safeguarding Cases* – also written by the NIASP. These restate and expand the definitions, e.g. to "physical abuse" is added "Female Genital Mutilation (FGM) a form of physical AND sexual abuse" (p8); the definition of "Domestic violence and abuse" is expanded and references specialist services and a helpline (p11); the title of "Human trafficking" is amended with the addition of "Modern Slavery" and advice that this form of abuse "will always be reported to the police service" (p11); similarly, the definition of "Hate Crime" notes that "the response…will usually be to report the incident to the police service" (p11).
57. The Procedures describe the role of "Adult Safeguarding Champions" - which the policy stated, "is intended to encompass the roles of the 'Nominated Manager' referred to in the Volunteer Now Standards and Guidance document 'Safeguarding Vulnerable Adults – a Shared Responsibility[22] and the role of the 'Alerting Manager' in the NIASP Adult Safeguarding Strategic Plan 2013-2018" (p25). The Operational Procedures are less specific proposing that "the Champions should be within a senior position within the organisation (p14). They are expected to be a resource to their own organisations, compile "an Annual Safeguarding Position Report," "consider whether the concern is a safeguarding issue or not" (p19), and "refer to HSC Adult Protection Gateway or PSNI" (p19). *If it is determined that the concern(s) do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and reasons for not referring to the HSC Trust* (p20) … *In the majority of cases where serious harm has been identified, the threshold for referral to the HSC Trust Adult Protection Gateway Service will have been met…referral to this service may not be the most appropriate response…for example, a peer on peer incident where capacity is a concern [may merit] an alternative response* (p23). The latter includes referral to the RQIA for action… *in respect of quality of care concerns… reassessment and review of service user/carer's needs… mental capacity assessment… action taken under complaints procedures… referral to: an advocacy service; another service… [and] a strategy to manage risks within a complex group living environment* (p23-24).
58. The Operational Procedures advance the Human Rights Act 1998, cite the Criminal Law (Northern Ireland) Act 1967 and the role of consent in determining a professional response.

[22] Dated 2010. Its subtitle is *Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults.* It is a 136-page document

The procedures state that capacity assessments should establish, *whether the adult in need of protection/ adult at risk is able to make a complaint to the PSNI and/or give legal instruction… has the capacity to be interviewed by the PSNI* (p29).

59. The Procedures set out the "Roles and Responsibilities" of the DAPO, the *HSC Investigating Officer*, the *HSC Achieving Best Evidence Interviewer*, the Line Manager, the HSC Regional Emergency Social Work Service ("RESWS") and the RQIA. This reproduces most of the text contained in the 2015 Policy.
60. The six-stage procedures are detailed. The stages are *screening the referral, strategy discussion meeting, investigation/assessment, implementation of the protection plan, monitoring and review and closure*. The appendices are principally made up of sets of forms (p84-116) to be completed when an allegation is made, through to a "Closure/ transfer summary meeting."
61. With reference to planning, the 2015 adult safeguarding policy defines two types:
    - *Care plan: a care plan sets out the assessed care and support needs of an individual and how those needs will be met to best achieve the individual's desired outcome. The individual should be fully involved in the development of the care plan* (p56).
    - *Protection plan: A plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm* (p59).

    The definition of the protection plan is repeated in the 2016 operational procedures (p75) and the joint protocol (p55).
62. The 2016, *Joint Protocol* identifies a specific protection planning role for the RQIA.
    - *With regard to the Joint Protocol RQIA are a key partner in relation to investigations and protection planning in all regulated services* (p12).
63. Subsequent references to an *interim protection plan* (p24, 34, 97), and *single agency protection planning* (p35) give way to an *initial assessment and/or implementation of an Interim Protection Plan* (p36). On page 37 it is proposed that *when the investigation and/or protection plan have the potential to infringe on the human rights of others, focused consideration needs to be given to this issue.*
64. The NIASP's Annual Report April 2017 – March 2018 conflates the plans:
    - *Care and Protection Plans are the actions taken by HSC Trusts to protect an adult from further harm, where it has been alleged that they may have been subjected to some form of abuse, neglect or exploitation* (p16).
65. The Report notes
    - *…that some investigations will refer to group living situations where one investigative process may include two or more adults, whereas a Care and Protection Plan is associated with an individual adult in need of protection. Consequently, it is not unusual for the number of investigations and the number of Care and Protection Plans initiated to be slightly different* (p15).
    - *The downward trend in the number of Care and Protection Plans initiated is slightly less marked than the trend in relation to investigations commenced. Again, this may be an*

indication that new thresholds are being applied and that high-risk situations are being identified and managed appropriately (p17).

POINTS TO CONSIDER – Learning and Change

- ✓ Legislation impacts on safeguarding practice across health, social care, regulation and policing. It requires and empowers practitioners to respond in a lawful manner to their everyday work – and it trumps policies and operational procedures.
- ✓ Over two years, terminology has embraced "care plans," "protection plans," "care and protection plans" and "interim protection plans" with no clear direction regarding their relative status.
- ✓ There is a compelling case for adult safeguarding practice "shadowing" the practice envisaged if adult safeguarding legislation is to be introduced.
- ✓ The expectation that Care Managers operating as *HSC Investigating Officers* should ensure "a safe and high-quality service" strays into inspection territory.
- ✓ The profile and impact of the work of Adult Safeguarding Champions is low. Their work has not developed in the way that was envisaged in *Adult Safeguarding: Prevention and Protection in Partnership.*
- ✓ There has been no evaluation or impact assessment of the quality and effectiveness of adult safeguarding in Northern Ireland, taking account of the contrasting priorities and arrangements of RQIA inspections, professional regulation, law enforcement, complaints, clinical governance, serious adverse incidents and internal disciplinary processes.
- ✓ The policy and operational procedures were intended to result in regional coherence and a unified approach. This has not happened. Each HSCT has adopted different criteria, processes and documentation.
- ✓ The training and development of professionals involved in safeguarding practice merits a higher profile.

66. A professionals' workshop during February 2019 concluded that Adult Safeguarding was prone to a "loss of focus."
"The process has become the focus and common sense is lost. //Protecting the person is de-prioritised as you work your way through the procedure. //It takes over from Person-Centered care. //The person should be our first priority and the form-filling a secondary consideration. //All we are doing is tracking what's been done. It doesn't keep anyone safe. // Safeguarding can result in automatic suspension [of staff] – so why would you report? //Everything comes to us…We're overloaded. //Professionals are working to different thresholds. //There's a reluctance to engage in institutional investigations yet over half of the referrals concern homes. //Different Trust responses are confusing for the homes. //Why are pressure ulcers coming to safeguarding? // There is currently no culture for us to reflect – to look back and question whether or not different approaches might have helped. // We don't want to feel judged because there is no clear way of responding. // We want space to explore alternative

pathways…to think about the evidence base for recovery…and for communicating. // We gather so much data and no one is looking at it. // RQIA won't consider anything that they describe as "third party information." They ask us to get on with the safeguarding investigation and "let us know what happens."//Such skewed priorities – the damage to public confidence is terrible. //The care management role is now a social work role…but for those people in long term placements, we should not be doing the job of the regulator. // Trusts should not have inherited the task of inspecting homes from the regulator."

67. The loss of focus is played out in (a) the "Interim Protection Plans," for example: *body map completed…30 minute observations…NOK informed…GP to be contacted…had a meeting…family do not wish to make a formal complaint to the Police;* and (b) decision-making following a safeguarding referral, for example: *NFA…Please complete the relevant forms and forward to QA and Support Team for clarification…ASGT were initially given an incorrect bruise measurement…wish to inform QAST about this practice concern.*

Section C: How the Adult Safeguarding System works

> "It's all disconnected and disjointed" – relative of a DMCH resident
>
> "Nurses don't want to work in homes because of safeguarding requirements. They are worried they will miss something and get into trouble"- Care Home Manager

Home Truths

68. The evidence gathered during the COPNI investigation at DMCH and reported as *Home Truths* supported the following conclusions:
    - *The most important theme emerging from the investigation, and one which covers a broad range of issues, is safeguarding. This theme is about the importance of protecting those most vulnerable in our society.*
    - *Most of the residents in Dunmurry Manor were vulnerable adults at risk of harm as defined in the 2015 Adult Safeguarding Prevention and Protection in Partnership Policy (the 2015 Policy). Their personal characteristics and life circumstances resulted in their exposure to harm through abuse exploitation or neglect being increased.*
    - *Many of the residents in Dunmurry Manor were adults in need of protection. They were unable to protect their own wellbeing and rights, and the action or inaction of another person or persons, of the RAs[23] under investigation, caused them to be harmed.*
    - *The findings show that there was a clear and immediate risk of harm. Evidence gathered demonstrates this abuse materialised in the form of physical abuse, psychological abuse, institutional abuse and neglect* (p13).
69. COPNI's evidence[24] included: failures to report notifiable incidents; assaults by residents on each other; inconsistency between HSCTs over what constitutes a "quality monitoring" incident and what constitutes an "adult safeguarding issue;" physical security issues; lack of contemporaneous recording of observations; a confusing variety of documentation; lack of evidence of 15 minute observations taking place, the purpose of which was unclear; fear of residents entering other residents' rooms at night; reported incidents of locking bedrooms from the outside; incomplete safeguarding records; medication errors; inadequate HSCT and RQIA responses to evidence of institutional abuse; delays in calling ambulances and/or GPs; and inhuman or degrading treatment.
70. *Home Truths* recommended:
    i. *An Adult Safeguarding Bill for Northern Ireland should be introduced without delay. Older People in Northern Ireland must enjoy the same rights and protections as their counterparts in other parts of the United Kingdom.*
    ii. *The Safeguarding Bill should clearly define the duties and powers on all statutory, community, voluntary and independent sector representatives working with older people. In addition under the proposed Adult Safeguarding Bill there should be a clear duty to report to the HSC Trust when there is reasonable cause to suspect that there is*

[23] Relevant Authorities
[24] The Review has not re-investigated the COPNI's findings.

an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries.

iii. *All staff in care settings, commissioners of care, social care workers, and regulators must receive training on the implications of human rights for their work.*

iv. *Practitioners must be trained to report concerns about care and treatment in a human rights context.*

v. *Policies and procedures relating to the care of older people should identify how they meet the duty to be compatible with the European Convention on Human Rights.*

vi. *The registration and inspection process must ensure that care providers comply with the legal obligations imposed on them in terms of human rights.*

vii. *The Department or RQIA should produce comprehensive guidance on the potential use of covert and overt CCTV in care homes compliant with human rights and data protection law* (p30).

71. The Review Team drew on the findings documented in this Evidence Paper to advise DH on its possible responses to COPNI.

POINTS TO CONSIDER – Learning and Change

- ✓ It is understood that the shortcomings of the current arrangements are acknowledged and it is accepted that change is required prior to the enactment of legislation.
- ✓ The requirements of legislation could be initiated via consultation and the perspectives of principal stakeholders shared with an incoming Minister.
- ✓ Given the high profile of the covert use of CCTV, RQIA should be invited to consider undertaking a consultation to build on the guidance it issued during May 2016.[25] The latter is unequal to the challenges which have arisen in care homes and hospitals across the UK, appears dismissive of people's relatives taking matters into their own hands by installing cameras[26] and is unprepared for residents who use social media, e.g. patients' sharing pictures of hospital food in England and Wales.[27] The likelihood of care homes promoting digital - visual and text - communications is increasingly attractive to residents and their relatives. It has the potential to provide "real time feedback" to RQIA concerning residents' and families' experience of care homes.
- ✓ The provisions of the Regional Contract embed essential training requirements. Independent sector providers should be engaged to ensure an overview of all existing training and ensure that it incorporates human rights.
- ✓ A regional, outcomes-based model of evaluation of learning, that is relevant to care homes and inclusive of human rights, should feature in the commissioning and design of training.

[25] www.rqia.org.uk/RQIA/files/01/01e1fbdb-8b2e-4c20-b102-6215cce13961.pdf (accessed 18th July 2019)

[26] Paragraph 5.2 of RQIA 2016 guidance states: *Where [covertly secured images are] related to allegations of abuse of vulnerable persons or other unlawful acts, it is likely that these will be passed to relevant law enforcement and safeguarding agencies without first being viewed by RQIA.*

[27] https://www.bbc.co.uk/news/uk-49450595 (accessed 24 August 2019)

- ✓ Policies, procedures and monitoring of training by RQIA is part of its registration, inspection and annual assurance processes.[28] Inspectors are well-placed to establish their compatibility with the European Convention on Human Rights and all legal obligations.

Adult Safeguarding Data concerning Dunmurry Manor Care Home

72. The Review Team collected and considered adult safeguarding data related to DMCH. Some of the information provided concerned individuals and was shared by their relatives. Some had been gathered for the Commissioner's investigation[29] during 2017, and some with the assistance of the DH during December 2018. The Review was not charged with re-investigating matters that COPNI had already considered nor was it duplicating the DH's audit.[30] The Review has sought to examine the system and identify data which showed how well the various processes served care home residents.

Data provided to COPNI

73. Adult safeguarding is a relatively new, yet fast growing area of work. Its lack of boundaries is reflected in the nature of the HSCTs' referrals made between DMCH opening in July 2014 until 31 March 2018. The absence of a consensual view *within* two HSCTs on whether there should even be a safeguarding referral is reflected in Table 1. The HSCTs were exercised by the task of collating the referral data for the purposes of the COPNI investigation since there are several, summarised versions of safeguarding events in residents' lives. It is possible that COPNI's *Home Truths* and this Review are disadvantaged by the HSCTs' summarising processes which, it is speculated, involved selecting, simplifying, possibly paraphrasing and transforming accounts of adult safeguarding incidents into Tables. There is no material which suggests that the HSCTs were familiar with the task of coding either incidents or the responses to these for the purpose of within-HSCT analysis. Given the different approaches of the HSCTs, the region is poorly placed to organise across-HSCTs safeguarding information in such a way that conclusions may be drawn and verified. The Review Team draws on the data that is available.

[28] These include an annual calling to account – objective challenge (primarily by the DH), in terms of following up and following through on what has been planned; and scrutinizing how the organisation addresses material risks – including the unexpected which may interfere with the achievement of strategic objectives. To what extent does the material RQIA places in the public domain - most particularly the annual report – fairly reflect its operations?

[29] The Review Team was not confident that all safeguarding information from the HSCTs had been accurately presented to COPNI. During the review, adult safeguarding information was revised to give assurance of completeness and accuracy. That process revealed new information

[30] See paragraphs 7, 133 and 199

Table 1 Examples of resident on resident harm and actions taken [31]

HSCT	Events	Action Taken
Belfast	"Resident on resident altercation"	Decision: Level 2 [32]
	"Resident on resident – grabbed by the neck"	Decision: Level 3
	"…was deliberately elbowed in the face by a male resident"	"no injury sustained…no further action"
South Eastern	"Punched on cheek…"	"GP and Next of Kin (NoK) informed; screened out of VA (Vulnerable Adult) process"
	"Resident on resident incident. Unwitnessed by staff"	"Closed as risk management. Paperwork to be completed"
	"Resident allegedly struck another resident. Resident fell – no injuries"	"Dementia/ risk management by community team"

74. Table 1 underscores a critical need to reformulate the practice of adult safeguarding. The demands of presenting events, incidents and accidents in writing are considerable. The adult safeguarding information submitted to COPNI and the different information shared with the DH and Review Team demonstrates that the post-event information gathering is ambiguous about whether or not incidents merit directing to safeguarding, contract compliance, quality monitoring, care management, complaints, the RQIA (via notifications) or the police, for example. The administrative retrieval of safeguarding information from all HSCTs within the 2014-2017 timeframe begs two questions:
    - What it is the purpose of gathering this information?
    - Why was scrutiny of a "file audit" necessary to ensure that the safeguarding information was comprehensive?
75. A spotlight on one Table spanning 77-pages features the processes adopted by a single HSCT. There are five columns of information: "Process – ASG, Complaint, Quality etc; Date; Issue/ concern; Client/s involved; Staff/s involved; [and] Outcome and date." A caveat at the end of the Table states, *Please note that Adult Safeguarding referred cases may have screened out to Quality Monitoring, risk management or dementia management*. This suggests that information within the Table requires more explanation than that which has been entered.
76. The most frequently cited process concerns "Quality Monitoring" [17 citations, QM], followed by "Vulnerable Adult" [13, VA], then "Complaint" [5] with the following cited on two occasions each: "Adult Safeguarding…Fall…Medication…email."

[31] From information submitted to COPNI

[32] Although the levels do not feature in either the regional policy or procedures, they are deployed by the Gateway Team as follows: level 1 – *screened but is determined as not requiring a safeguarding investigation…Level 2 are referrals that are screened as requiring a safeguarding investigation, but this is undertaken by the Community Social Work Team…Level 3…screened as requiring as safeguarding investigation, but this is undertaken by the Adult Safeguarding Team*

77. It is not clear why "email…incident…physical injury…QM referral re poor documentation… compliment and staff behaviour" are listed as processes. More understandable processes are "Contracts…RQIA information…RESWS and Trust contracts meetings." However, it does not make sense to scrutinise these processes as distinctive and separate because their content is not exclusive and more than one process was invoked for some residents e.g. "VA transferred to QM."
78. Turning to the column "Outcome and date," the latter is occasionally recorded, sometimes with the bracketed reference to the dates of emails. With few exceptions the outcomes listed are process-oriented, that is, the results or consequences for individual residents are not described. The following examples illuminate the process-oriented approach which is characterised by a telegram style:

    Case closed. // Trust formally request an action plan. // Risk Management. // Incident not reported to care manager therefore not recorded in the file. // Requested additional information. //…felt it was a Quality Monitoring. // Screened out of ASG process for progression under Risk Management. // Quality Management referral completed…to address the issues raised. // Meeting arranged [then] cancelled. // To ensure RQIA are informed. // Referred to keyworker for dementia management. // Closed to Risk Management. // Arrange a review. // Assistive technology discussed. // Case reviewed. // Enhanced monitoring nurse. // Ongoing enquiries. // To progress under risk/ dementia management. // Concluded investigation and shared the findings with NISCC. // Investigated. // Quality Monitoring addressing. // Requested update re the home's internal investigations. // Untoward incident report completed…I requested a copy…this had not been received. // Human Resource investigations. // To address with staff – no other outcome recorded. // Investigated and allegation substantiated. // Audit may be completed by Trust quality monitoring.
79. One "issue/concern" states, "[named professional] carried out an unannounced inspection" and the "outcome and date" states "No issues/concerns identified…we will complete an in-depth audit of documentation through the clinical facilitators." It does not appear that this refers to a regulatory inspection because the RQIA is not cited in the "process" column.
80. The "issue/concern" column is illuminating since it describes in an edited way the events in residents' lives and the preoccupations of their relatives. For example, tangible evidence of inattention to:

    a) residents' hygiene, comfort, grooming and personal care:

    - *…in pyjamas and poorly shaven*
    - *…to be showered x3 daily and…teeth cleaned daily…doubts this is happening*
    - *…continence needs were not met…*
    - *Hair not washed regularly*
    - *…residents wandering in [relative's] bedroom…*
    - *…witnessed staff stripping [relative]…on the toilet [and] staff washed [relative] down with a face cloth…did not dry [relative] …feet filthy and black with dirt…*
    - *…call twice daily to ensure [relative] is having food and drinks*

- *Missing clothes on an ongoing basis…clothes soiled with faeces left in wardrobe with clean clothes*
- *clothes disheveled and what appeared to be vomit down [resident's] side*
- *…witnessed staff removing a wet pad and putting on a clean one without cleaning [resident] or using…barrier cream…resulted in…raw skin*
- *…other people's clothes were always found amongst [relative's]*
- *…toenail grew over the top of [relative's] toe*
- *…needed support tights…not used…*
- *[relative advised that resident was] playing up because you are here.*

b) Residents' medication, healthcare,[33] nutrition and hydration

- *Food served is of a very poor quality*
- *no assistance with eating or drinking*
- *…dehydration highlighted…*
- *…the home failed to provide the appropriate aftercare e.g. hospital appointments not attended*
- *…significant weight loss from admission…*
- *fall mat never activated*
- *[after a resident's fall out of bed, relative was told that bedrails were] "not allowed"*
- *…staff told [relative that resident] was falling deliberately*
- *flu vaccination not received*
- *home failed to complete basic physical checks e.g. infection, medication*
- *lesions…on [resident's] buttocks*
- *medication increased without GP calling. It was directed over the telephone"*
- *[resident's] medication was incorrect for three weeks*
- *Home had not noticed the bruise*
- *Tablet found on [resident's] floor*
- *Medication administered by unqualified staff*
- *[Relative] left a marked jug of water in [resident's] room…remained untouched/ refilled/ refreshed for three weeks*
- *Poor management of [TIA incident] by the home*
- *CPN records that home continually fail to follow advice provided…verbal information…does not match written reports*
- *supplied dressings not available…lack of nurse training…appropriate level of drugs not ordered.*

c) Residents' quality of life:

- *unattended sitting rooms within the home*
- *new hearing aids missing at times*
- *Lack of activities…bored*

[33] The NIAS reported that its log of calls to DMCH revealed "119 call outs, 8 recorded as falls" between May and December 2015; and "113 call outs, 45 recorded as falls" during 2016. Within this period the NIAS attended four residents on 21 occasions. The process typically involved contact with GPs who advised contacting NIAS

- *no continuity of care*
- *no respect/dignity – unexplained actions*
- *…last fall[34] resulted in a broken hip which [resident] never recovered from*
- *[relative] had a major emotional breakdown on Sunday evening…very distressed and inconsolable… [the following day] the nurse on duty was [unaware of this]*
- *…requested that one male staff swap with female carer…refused*
- *staff slow to respond [to alarm mat]*
- *Continual problem of other residents wandering in and out of mother's room*
- *concerned about [resident's] physical and mental health*
- *…inappropriate moving and handling*
- *resident was left sitting in living room all night…continence needs were not met[35]*
- *[On admission to hospital] improvement in mental and physical health…eating well and seems less anxious*
- *Interaction between staff and residents is lacking...80% of [resident's] clothes missing…poor quality of life due to staff attitudes*
- *curtains…were covered in faeces…*
- *Clothes soiled with faeces left in wardrobe with clean clothes*
- *glasses were broken and no optician services available.*

d) The home's fabric, routines and communications:

- *…has witnessed delays in responding to fire alarm*
- *[relative] allegedly told if you have that many complaints move [resident] to another home. We don't offer 1 to 1*
- *Staff untrained in dementia care*
- *concerned about number of changes in management…*
- *lack of organisation*
- *Too few [staff] on duty…agency staff…many do not have English as their first language*
- *some staff were exceptional, but they left…constant change of manager*
- *…a culture of denial…young girls run the place*
- *Staff were very supportive and cared for [dying relative] a peaceful environment*
- *…frustrated attending meetings and listening to platitudes*
- *permanent staff were very helpful…*
- *…dismayed that [resident] was referred to as a number*
- *…feels the new manager has a poor attitude*
- *Staff approachable and good*
- *Staff when interviewed had an incredible lack of capacity to recall events*
- *[the home's managers] talked the talk but did not address issues*
- *The Dunmurry booklet betrays a fairy tale and is totally misleading*

[34] There were almost 100 residents' falls between 2016-17.

[35] "The resident refused to leave the sitting room and became very anxious when attempts to move her were made. Staff in the home sat with her, ensured she was warm and gave cups of tea and attention until she was willingly ready to go to bed." Information provided by the South Eastern HSCT

- *[Home/ management] did not send their condolences when [relative] died*
- *…when [resident] admitted to hospital [home] staff visited [resident] on their day off…home spotless*
- *[Named professional] called to home to carry out a VA investigation initially was unable to gain entry…eventually a visitor let [professional] in.*[36]

81. During 2016, one family expressed frustration that their relative's Care Manager was "continually off work." During 2017, the distress of a relative who was unable to confirm whether a review had taken place resulted in a HSCT professional providing "[relative] with COPNI number and advised [the relative] of [its] role." Additionally, during 2017, another relative was advised that [named professional] had completed a QM referral in respect of [resident]."
82. Between November 2015 and December 2016, RQIA is cited on ten occasions within the documentation about this HSCT.[37]
    - When visitors "witnessed a resident being manhandled" in "May/July" 2016, it was noted that there was a "Failure to report to Trust or RQIA"
    - During September 2016, "all issues of concern and June RQIA report discussed"
    - During November 2016, a relative had "spoken to RQIA about…concerns"
    - When a resident fell and sustained a fracture during December 2016, it was noted that a "Copy of RQIA notification [was] received 20/12/16"
    - The "actions from the investigation" arising from a resident's admission to hospital during May 2016 noted "Also all actions that were recommended in concluding report such as having processes in place for referrals to Trust RQIA *(sic).*"
    - Re a "resident on resident incident" during August 2016, it was noted, "Advised nurse to ensure RQIA informed and forward copy"
    - "RQIA [were] informed" about an allegation[38] during September 2016 that a carer was locking residents into their rooms
    - An "update" was sought from RQIA during October 2016 concerning its inspection findings and "non-compliances"
    - During November 2016, the RQIA were party to a meeting concerning a resident and "themes emerging from Dunmurry Manor"
    - An unannounced care inspection during November 2015 was cited.
83. A small number of "outcome" examples from the adult safeguarding data suggest that improvements to residents' circumstances *may* have resulted from safeguarding meetings, investigations and processes. For example:
    - *Spoke to [relative]…happy with the placement and feels things have improved since the review…*

[36] Staff were meeting at the time of the visit
[37] Although it is the responsibility of home managers to notify RQIA, the Trust will advise them to ensure a report is made. This may not always be recorded in documentation - SEHSCT
[38] This was "unsubstantiated"

- [Named professional] *is reviewing the incidence of falls in the home…Trust's Falls Coordinator…agreed to provide input…*
- "Training planned" re fire drills
- District Nurse visited and established that the skin integrity of a resident "was good." This followed an allegation by an agency nurse
- *Family have terminated [their] place at Dunmurry Manor*
- The "locker [was] removed" from the room of a resident who had hit their head on it
- Another resident's feet were to be "monitored monthly." It is not known whether this happened
- *…checked curtain…now clean; however, in [resident's] drawer there were bandages with what looked like faeces on them…now removed*
- "Buzzer volume was turned up" after a relative reported "a delay in buzzer response"
- *…the risk to clients has been managed via your investigation and subsequent removal of the alleged perpetrator*
- *…no evidence found to suggest that residents were woken early to complete personal care*
- *In general, a friendly and homely atmosphere. As commissioner of placements within Dunmurry Manor we will complete an in-depth audit of documentation through the clinical facilitators*.

84. A separate, 13-page Table concerning residents from SEHSCT contains a column entitled "Identified learning." This title is misleading because the "identified learning"[39] challenges the appropriateness of the repertoire of the processes invoked and exhorts professionals to attend more carefully to processes:

> *Clear decision-making is required re screening out and recorded on appropriate documentation. // Concern should have been screened out and should not have been recorded on Adult Safeguarding documentation. // As a result of file audit this referral came to light. It was appropriately screened out and managed under risk management. This was not included in the information to COPNI. // DAPO needs to ensure full documentation is fully completed detailing decision-making. // Adult safeguarding referral was not appropriate as this [resident] was causing the harm to another resident…Inappropriate use of ASG documentation. // Appropriately screened out and recorded. // DAPO to ensure timely progression of the investigation and the outcome of the investigation communicated and appropriate recording and use of documentation (sic). // The information sent to COPNI references these as 4 ASG referrals when in fact there were 2 referrals. There was a request for subsequent review following issues raised by NOK about the initial investigation process. // DAPOs reminded to only record Adult Safeguarding documentation if investigation commenced and communicated to NOK. // Appropriate process was disciplinary – managed by DM.*

[39] This seeks to identify areas to be taken forward for learning - SEHSCT

85. One observation merits attention because it confirms that the decision-making rules about the various processes may be trumped by other considerations:

> *Dunmurry Manor had managed the allegation appropriately under their HR process. A report of their findings/ actions was provided to SEHSCT and should have sufficed without instigation of an adult safeguarding review. Pressure from a family member led to attempts to demonstrate that all possible processes had been followed*.

86. A five-page Table identifies the Designated Officers responsible for the adult safeguarding referrals relating to 35 residents. Some of the outcomes cited include:

> *Strategy and case discussion both cognitive impairment. // Protection plan in place. // Cognitive impairment. // Protection plan in place. Care plan for client. // Investigated - closed. // Investigated and recommendations made. // Closed following information gathering. // Unable to confirm what happened Quality monitoring (sic). // Recommendations made. Staff induction process and supervision. // Cognitive impairment. // Not substantiated recommendations made.*

87. A two-page Table summarising the "date, VA, AP, incident, decision [and] PARIS"[40] cites "the red book" in the decision column i.e. "Not in red book" x7. This is a reference to the electronic record of all referrals to the Adult Protection Gateway Team which replaced a red book into which referrals were handwritten.

POINTS TO CONSIDER – Learning and Change

- ✓ There should be certainty that there is a reliable way of collecting, coding, storing, analysing and retrieving data and information about adult safeguarding across the region.
- ✓ Adult safeguarding in NI is a process-creating enterprise. It needs re-orientating towards outcomes for the individuals concerned. Neither "cognitive impairment" nor "dementia" are credible outcomes.
- ✓ The criteria for determining the types of procedural responses to incidents appear unquestioned. This is not the problem of those responsible for inputting or collecting data. Simplifying a confusing array of processes is necessary.
- ✓ Accounts of incidents and events should combine factual description and reasoned explanations.
- ✓ Post-event decisions ought to tackle the causes of harm and identify readily understandable ways of minimizing the risk of further harm.
- ✓ Conclusions drawn depend on the quality and confirmability of the information gathered so that others may reconstruct and corroborate them. The system should be able to depend on documentation, such as risk assessments and management, to prevent harm, protect people and enable practitioners to learn.
- ✓ The decision-making concerning the appropriateness of the processes invoked ought to point towards "learning identified." The Review finds that it does not.

[40] Primary Access Regional Information System

Belfast HSCT's Adult Safeguarding referrals concerning Dunmurry Manor Care Home

88. It took time for the HSCTs to respond to the Office of Social Services' [DH] request for information. The Review Team found it difficult to establish a comprehensive list of all safeguarding referrals made in respect of DMCH. An initial scrutiny suggested that there were 48 referrals associated with 21 Belfast residents. These numbers were subsequently amended since:
    - safeguarding referrals did not align with "file audit"[41] information
    - the criteria for "accepting a safeguarding referral" could not be ascertained from the referral information
    - the ways in which HSCTs' prepare referral information differs
    - terminology appears to have different meanings across the HSCTs
    - matters concerning staff conduct are usually[42] "screened to host Trust"
    - anonymised information concerning similar referrals potentially double-counts incidents/ events
    - the rationale for certain outcomes is not known.
89. With these caveats in mind, within the 2014-2018 timeframe, there were 23 Belfast residents at the home, four of whom were men. There were 54 referrals in total. During 2014 and 2015, there were four and seven referrals respectively. During 2016, there were 27 referrals and during 2017, there were 15. There was a single referral during March 2018. Three referrals concerning three residents pre-dated their admission to DMCH. Two referrals were about men in hospital. The HSCT removed these from the information. [43]
90. It is noteworthy that nine Belfast residents (six women and three men) were the subjects of safeguarding referrals within the first month of their admission to the home.
91. Three residents, two women and a man, were the subjects of between seven and nine referrals.
92. The greatest number of referrals concerned "resident on resident" harm, including residents hitting, slapping, pushing, punching their peers and having verbal altercations. Although one resident had their "hands around neck" of another resident… "no significant harm [was] noted." There is no doubt that some of these incidents would result in foreseeable distress, e.g. "hair grabbed from behind." It is remarkable therefore that within the transcribed "outcomes" are more than 20 assertions of "no actual harm" and more than 20 statements, "No further action" which appears to be synonymous with "safeguarding investigation closed."
93. One referral resulted from a medication error. Others arising from staff behaviour included residents "allegedly verbally abused," and the use of social media. Although these were "screened to SEHSCT as the host Trust…as it related to a staff member as potential abuser

[41] See paragraph 133. File audits were part of inter-HSCT monitoring and were followed up by Quality Monitoring Officers. The Review Team noted criticisms of these, e.g. unplanned monitoring visits; Quality Monitoring Officers' adopting different approaches; and resulting reports unavailable to the homes

[42] There was a dispute about how a referral was handled between the funding HSCT and the host HSCT

[43] Two of these were from SEHSCT. The Review Team understood that they were included because the men later became residents at DMCH

and had wider safeguarding implications," the Human Resources outcomes and/ or impacts on residents were not detailed.

94. One resident returned to the home in which they had lived before DMCH with another resident. Their absence led to the PSNI investigating missing persons. The outcome was "Care plans and risk assessments updated."
95. There were fewer than ten referrals concerning sexual behaviour and potential assault. Some were not directly observed and others concerned touching through clothes.
96. The circumstances of a resident who sustained a fracture were attributed to "a history of falls" and deemed to merit "follow up from Quality Assurance Team." One referral concerned the allegation of a resident's clinical neglect. This resulted in essential medical intervention and ultimately, "in a no prosecution decision" by the Public Prosecution Service for Northern Ireland ("PPS"). Necessarily the PSNI investigated this case and the PPS determined that there were no grounds on which to bring prosecution. It was also involved in discussions concerning five other safeguarding referrals.
97. Five of the transcribed outcomes referred to residents' dementia or memories of incidents. For example:
    - *…unable to contribute to clarity about scratch marks*
    - *Neither had any recall of the incident* [juice was poured on a resident]
    - *Agreed as dementia management and investigation closed* [resident fell following an altercation]
    - *…concluded as dementia management issue* [face slapped]
    - *Unable to recall the verbal abuse* [by staff member]
    - *…screened as behaviour management rather than safeguarding* [face slapped].
98. A referral concerning bruising led to "follow-up" from the community team and liaison with a resident's relative who "had no note of bruising or concern." The family of a resident who was the subject of more than seven referrals "did not wish to take any further action…did not wish to pursue a formal complaint to PSNI…did not wish any further interventions." Another family notified about a referral stated that they had "no particular concerns."
99. The outcomes transcribed appear limited, most particularly when onward referrals are cited. Given the levels of risk to which residents were exposed – most notably from other residents – there is no reference to risk management interventions. "Agreed continuing vigilance with home" or yet more "plans" are barely credible in view of the likelihood of residents harming each other. It is noted of one resident involved in harming another, "there had been two previous incidents recorded." Knowledge of an individual's behaviour is essential if homes are to manage the behaviour and its implications for others. The bruising of one resident was "screened as a quality concern rather than safeguarding as no significant harm noted." The involvement of clinicians such as a GP or specialist medical input at consultant level was rare and associated with a single resident. It was noted of one resident that they had been "transferred" from the home. After five incidents of being hit, slapped, and mistaken as the close relative of another resident, the person concerned was "moved to the residential part of the home."

100. Various claims concerning 19 residents concluded "no harm noted," even though they sustained cuts, "superficial" injury, bruising, falls, scratches and skin marks due to the actions of other residents. It is possible that professionals completing the safeguarding forms were reassured by such recorded statements as *No injury was sustained although [resident] was noted to be distressed at the time. //…was surprised but not hurt and was easily settled. //…no injury noted [resident] distressed initially. //…no ill effect noted. //…was distressed at the time.*
101. Since anyone in pain is locked in a struggle for relief and potentially fearful of recurrence, non-clinical assertions about whether or not individuals have been harmed are ill-judged. People with dementia still register that something they called pain is making an impression on their bodies. They may be unable to articulate this and/ or may express pain through their behaviour. The Review Team's scrutiny of the DMCH referrals found that no safeguarding referrals cite individual's "fears."

POINTS TO CONSIDER – Learning and Change

- ✓ There was a single reference to "risk" in the outcomes transcribed concerning Belfast residents. A regional approach to risk management is required.
- ✓ Only one of the three people subject to seven or more referrals had a "care review" and this occurred after the seventh referral. An eighth referral was "followed up by a care worker." It is important that there is consistency across all HSCTs concerning care reviews; and what these should entail – they should always involve the person who is the subject of the review, family members and carers.
- ✓ The basis on which "no actual harm" is stated is not discernible from the referral information.
- ✓ "No further action" is a frequently cited outcome arising from screening, investigations and claims about whether or not "harm" has been established.
- ✓ The rationale for the processes of onward referrals to the host HSCT or to the Quality Assurance Team/ monitoring is not clear.
- ✓ Determining "dementia management" or "behaviour management" as outcomes should cease. The documentation should record the care and support steps to be taken and describe how the intended and actual interventions result in benefits for individual residents.
- ✓ Families are instrumental in (i) alerting a home to problems and (ii) determining whether or not action is taken as a result of allegations. Attending to their alerts and questions is invaluable to residents and relatives.
- ✓ It cannot be determined from the documentation[44] what resulted from Notifications to the RQIA about the harms sustained by residents.

102. On 18-19 February 2019, Belfast HSCT professionals acknowledged the uncertain distinction between poor and neglectful practices and noted:

[44] Runwood has not provided this documentation although it has been requested on several occasions.

"Where does common sense feature? // Too much time is spent batting concerns about quality to the RQIA who say "it's safeguarding" when safeguarding has no powers! // You hear "It's not in the contract" – why not? // There's no readiness to challenge...it requires courage to complain. // Can anyone explain why acute hospitals are treated differently? Why are hospital wards not regulated facilities? // Who should be taking the lead when, after a safeguarding investigation, the RQIA do an "unannounced inspection" and state that at the time they visited, everything's ok? // We suffer from a lack of Mental Capacity legislation and yet allow people to get tangled in cobwebs with Best Interests decision-making. // We owe it to families to engage with their perspective and to get it right. // We have to be clear about involving the PSNI when crimes are committed. // We try to get the thresholds right but they're different and it becomes a fog!"

South Eastern HSCT's Adult Safeguarding referrals concerning Dunmurry Manor Care Home

103. The South Eastern HSCT ("SEHSCT") is the host HSCT to DMCH. The information it provided to the Office of Social Services included the name of a resident (with an identical birth date but different date of admission to the home) who also features in the listing of Belfast residents. For the purposes of this Evidence Paper, the referral information concerning this resident was transferred to the Belfast data since the latter contained several referrals for this resident, and possibly the one cited by SEHSCT.
104. SEHSCT advised the removal of information concerning a small number of referrals since these pre-dated the admissions of three residents to DMCH. An additional two were identified by the Review Team – one referral had occurred seven months prior to the person's admission. They were removed.
105. Within the relevant timeframe there were 29 SEHSCT residents at DMCH, 13 of whom were men. There were 47 referrals in total. During 2014 and 2015, there were five and 12 referrals respectively. During 2016 there were 21 referrals and during 2017 there were eight referrals. There was a single referral during 2018. This referral pattern resembles that of the Belfast HSCT.
106. Two residents were the subjects of four referrals, two were the subjects of three referrals and eight were the subjects of two referrals. In contrast to the Belfast HSCT, three residents were the subjects of referrals within a month of their admission to the home.
107. Once again, the greatest number of referrals concern residents harming other residents by hitting, grabbing or pushing. Claims such as, *no serious harm…no harm…unsubstantiated, no serious harm* appear unduly reassuring in the absence of corroboration. It was noted of one incident that the, *Investigation could not establish if harm actually occurred*.
108. One referral concerned a medication error for which a GP claimed responsibility. There were around ten others arising from the behaviour of staff at the home regarding "poor" manual handling, staff members shouting at/ being threatening towards residents, the poor handling of a resident and staff declining to assist residents. There were staff suspensions, disciplinary processes were initiated and a member of staff was subsequently referred to the Disclosure and Barring Service by the home's manager.

109. Two referrals concerned two residents exiting the home and another resident found sitting on the wall of an enclosed garden.
110. There were three referrals concerning sexual behaviour and potential assault, one of which resulted in informing the RQIA. It was noted of the others that "there was no evidence to proceed with a criminal process and a PSNI investigation" and "PSNI referral but not involved. NOK did not wish to make a complaint." It is unclear whether all were the subject of referrals to the PSNI.
111. One referral highlighted the neglect of a resident. This was one of three residents who were moved to other homes. It was noted that "issues were raised with Dunmurry Manor" concerning neglect. In addition to a GP and paramedics, the PSNI was notified when a resident was found with several injuries. *This was managed under care planning*.
112. It is speculated that one family did not want their relative to be interviewed because of the potential trauma. Only three referrals referenced people's dementia and its manifestation.
    - *…unable to recall alleged incident*
    - *Both residents had dementia and lacked capacity*
    - [it is] *a feature of [the resident's] condition*.
113. The SEHSCT referrals confirm that contact with residents' families is instrumental in determining whether or not investigations proceed. For example:
    - *NOK consulted and happy that it is screened out*
    - *The family did not wish to pursue the matter*
    - *NOK informed and not wishing PSNI involvement* [there were seven such statements]
    - *NOK informed and did not want further action*
    - *NOK informed and did not want to make a complaint*
    - *[NOK declined to] engage with the investigation nor identify staff*.
114. These 'outcomes' [45] resemble those of the Belfast HSCT insofar as they are characterised by a lack of consistency. However, in contrast to the Belfast referrals, there are many references to risks, that is, *risk minimal. // Risk management meeting. Investigation closed. // Risk management plan in place [x2]. //Risk assessment and management plan. // It was referred to Risk Management [x2]. // …managed under risk management [x6]. // The manager had taken steps to put risk management plan in place*. The other "management" destinations cited are: *Managed under care planning by key worker. // Managed under care planning [x3]. // Referred to the Adult Safeguarding team for review and management. // Managed under complaints procedure. [46]// Managed under quality. // Managed under disciplinary" [x4].*
115. It is not known why a single "altercation" between residents resulted in informing RQIA. The latter was also "informed" about a referral concerning a sexual incident – even though similar incidents were documented about which the RQIA or PSNI did not appear to have been informed.

[45] The heading shaping SEHSCT's response is the "Outcome of screening and reason for decision/ description of concern reported/ record and actual harm"

[46] This concerned a resident who transferred to another home. It is the only reference to a complaints process

116. SEHSCT acknowledges that ten referrals "were not listed on the COPNI information." That is, they came to light during "file audits." A total of 23 referrals were "screened out" and the template indicates that a further three "should have been screened out." These concern a medication error; a relative's "concerns" regarding "low staffing levels…visible stress of staff…manager's ability to manage the home;" and a resident's attempt to leave the garden area.
117. SEHSCT shares non-clinical insights concerning whether residents sustained harm with 28 referrals associated with, *no serious harm*. One cited "significant harm" and arose from a fracture requiring hospital treatment. Typically, when referrals hinge on hospitalisation, neither the Belfast HSCT nor SEHSCT states whether harm is perceived to have resulted.
118. The SEHSCT's own analysis attributes its responses/ referrals concerning DMCH to the implementation of the 2015 regional policy, followed by its 2016 procedures and the accompanying training "regarding the language and new thresholds." The transition from the previous policy and procedures is associated with some "inconsistency." Furthermore, staff were responding to the perceived pressure of relatives "by escalating issues inappropriately under Adult Safeguarding." It was noted that HSCT and DMCH staff believed that they had to "report everything." It was "staff anxieties" about "institutional abuse" that meant "the thresholds dropped" and risk analysis and management were set aside in favour of "escalating everything to Adult Safeguarding." It was noted that discussion with line managers or DAPOs prior to submitting referrals would have constrained "inappropriate referrals." SEHSCT's solutions include a "permanent placement team…to create a relationship approach to support and in-reach" to homes; the creation of an Adult Protection Gateway Team; audits and action planning; the deliberations of a "monthly operational, cross-programme governance group;" and a review of,
    a) NI's Single Assessment Tool [47] and
    b) the regional procedures - which "have been challenging to implement."

POINTS TO CONSIDER – Learning and Change

- ✓ SEHSCT's clear distinction between "screened out" and "investigated" is not evidenced in Belfast HSCT's data.
- ✓ There is overlap, but little correspondence, between the two HSCTs indicating a need for a single regional approach.
- ✓ The "outcomes" cited by both HSCTs do not set out the implications of an incident or event for individual residents.
- ✓ Ensuring the safe juxtaposition and groupings of residents demands professional attention yet is reflected only occasionally by moving residents to other homes or to other areas within a home.

[47] Issued during 2012

Northern HSC Trust's Adult Safeguarding referrals concerning Dunmurry Manor Care Home

119. A single page entitled "Dunmurry Information 1 June 2014-31 March 2018," refers to the "institutional neglect" of three women, one of whom sustained two falls within a year. Although her initial fall was "substantiated," the second one was not, because at the time she had a significant Urinary Tract Infection and she had mobilized unaided. Another concerned a resident being locked in her bedroom. An investigating Officer met with her family who were regular visitors to the home. Since there was no supporting evidence and the family were satisfied with the care provided, this was not "substantiated," that is, no finding of institutional neglect resulted. Finally, the failure to record a resident's repositioning was investigated. However, a relative who was a daily visitor confirmed that the resident "was repositioned throughout the day." Thus, this safeguarding referral was not "substantiated."

Southern HSC Trust's Contract Compliance Process: Dunmurry Manor Care Home

120. The number of people the Southern HSCT had placed at DMCH was not known to the Office of Social Services of the DH. The latter confirmed that between June 2014 - 31 March 2018, this HSCT had received neither safeguarding referrals nor serious adverse incident reporting. However, the Trust did report eight concerns via a Contract Compliance process in relation to three residents, two women and a man. These spanned October 2016 - June 2017.
121. One woman was transferred to another nursing home having been the subject of two "contract compliance issues." Her family had questioned her diet, the quality of food provided, inattention to her care plan, inadequate assessments of her support needs and rough handling. The recorded remedies included the provision of care plans and the promise of an appropriate diet. A follow-up visit noted, *inter alia,* poor record keeping, inconsistent attention to care planning, the woman's "unexplained bruising," and reference to a "DNACPR[48] signed by the GP…" Since the woman's transfer to another home, the "measures to be put in place to prevent occurrences of this nature" included updated care plans and assessments, attention to staffing, the allocation of key workers to residents and the appointment of a Deputy Manager.
122. Another woman had sustained a fracture having stated that she had been pushed by another resident. Scrutiny of her records highlighted an undated and unsigned assessment of needs document, four body maps with "multiple entries" – all unsigned and "no integration of needs assessment and risk assessments into the plans of care." The woman's relatives subsequently discovered an open wound and reported her "unkempt" appearance. The home was reported as acknowledging that communication and documentation were not of the required standard. "The unit is now more stable having a full complement of senior staff…"
123. There were four "contract compliance issues" concerning a male resident. His care plan had been inaccurately re-written by a nurse who did not know him. It included a risk assessment for the use of a rollator which the man neither required nor used. It was noted that staff vacancies and "ongoing recruitment" meant that "all the issues highlighted will be

[48] Do Not Attempt Cardiopulmonary Resuscitation.

addressed..." During a follow-up visit there was no evidence of the promised updates to the man's records. It was expected that there should be

> *…an integration of risk assessments into care plans…informed by the needs assessment…updated risk assessments and information from other professionals as appropriate to devise a person centred plan of care based on best evidence-based practice.*

124. At a later visit it was noted that all care plans had been updated and computerized. However, still later, the man's risk assessments *did not reinforce the nursing assessment or…the overall plan of care.* The man's relatives questioned inattention to cutting his fingernails and it was not known whether an unexplained injury had been reported to the RQIA. It emerged that the bruising he endured was documented in the care record and accident book; *supervision was highlighting duty of care and standards of personal care* [and the] *deputy manager to audit personal care files*.

POINTS TO CONSIDER – Learning and Change

- ✓ The issues addressed by contract compliance resemble those which are referred to adult safeguarding by other HSCTs.
- ✓ It is possible that contract compliance places undue faith in the recruitment of staff and has unrealistic ambitions for the home's recording practice.

Summary of Incidents and Quality Issues

125. An additional wave of scrutiny was set out in a Belfast HSCT document entitled *Summary of Incidents and Quality Issues reported in Period 2015 - 2018: Dunmurry Manor*. This contains summaries of "adverse incidents and quality monitoring." It notes that the work of the Quality and Support Team was compromised by its own "staffing challenges" during 2014 - 2015. This resulted in no analysis of the information received, prompting a statement in the Introduction, "…we cannot be assured that our reporting for this period is accurate." The Introduction goes on to account for Quality Monitoring Reports ("QMRs"):

> *QMRs are incidents, accidents or quality of care issues reported by a member of staff employed by the Trust, from their own observation or through information received from another party, including a service user or family member. The QMR report will include details of the quality issue, accident or incident as reported by Trust staff and will be forwarded to the independent sector provider for further investigation and response.*

126. The first part of this document names 30 DMCH residents and lists 119 "incidents" of which 97 concerned residents' falls. These occurred between April 2016 and May 2017. The most typical "outcome" cited was "checked/assessed." Four residents experienced 57 incidents: nine, 11, 18 and 29 respectively. There is a single reference to "pressure damage" and six to "behaviour." In a column "Actual harm experienced," there are 86 "no injury" citations, yet one resident had six falls on the same day, another had two falls per day on four days. Other outcomes cited include *…close observation. // Training. // First aid administered. // Care plan reviewed/ updated. // Transfer to hospital. // Refer to Adult Safeguarding Gateway Team* ("ASGT"). *// …not recorded. // …reported. //* [and] *ambulance called.*

127. The second part of the document is a Table concerning 10 residents. Its title is, *Reporting from the implementation of the new Care and Support Team and reflect a new method of recording.* It spans January 2018 - March 2018, and confirms that falls remain a significant feature in residents' lives. One resident experienced two falls and another was the focus of three incidents. Although this Table pays attention to "actual harm experienced" and "level of harm," it is the outcomes which merit consideration since they concern the actions undertaken on behalf of residents.
128. For example, *First aid dressing applied to head wound. Neuro observations were recorded [and] 24 hours falls-log completed. Ambulance called…//Laceration cleansed, pressure applied with gauze…both pupils symmetric and reactive to light…GP contacted urgently…// Full body check, falls risk assessment completed and care plan updated…Reg. 30…sent…reassurance and resident reminded to call for help when needed…// Resident comforted, GP, NOK and key worker informed.* While these are more revealing than "checked/ assessed," it is not clear how such information is used.
129. The final part of the document concerns "QMRs from DMCH Sept 2015 - March 2018." These hinge on the circumstances of 11 residents, one of whom was the subject of two QMRs. Of the latter, one concerned the delayed reporting of a resident whose hair was pulled by another resident; and another concerned a resident whose face was marked with nail polish. Other QMRs addressed inattention to residents' personal care needs, management of incontinence, comfort, grooming and care of belongings. Two families questioned the home's inadequate numbers of staff since they associated it with poor practices resulting in pressure ulcers for example. It was noted of a resident who had fallen ten times in six months that the *quality team… advised the care manager that all incidents had to be reported to quality team whether or not client has sustained injury*.

POINT TO CONSIDER – Learning and Change

- ✓ A QMR appears to apply when the matter is deemed a management, practice or complaint/grievance type issue that is referred to the provider to address.

Notifications to the RQIA

130. Section 30 of *the Residential Care Homes Regulations (Northern Ireland) 2005* and the *Nursing Homes Regulations (Northern Ireland) 2005*, states that *The registered person shall give notice to the Regulation and Quality Improvement Authority without delay of the occurrence of:*
    a) *the death of any resident, including the circumstances of his death*/ the death of any patient, in the nursing home, including the circumstances of his death
    b) *the outbreak in the home of any infectious disease which in the opinion of any medical practitioner attending persons in the home is sufficiently serious to be so notified/* the outbreak in the nursing home of any infectious disease which in the opinion of any medical practitioner attending persons in the home is sufficiently serious to be so notified;

c) *any serious injury to a resident in the home/* any serious injury to a patient in the nursing home;[49]
d) *any event in the home* which adversely affects the care, health, welfare or safety of any resident*/ any* event in the nursing home which adversely affects the wellbeing or safety of any patient;
e) *any theft or burglary in the home/* any theft or burglary in the nursing home;
f) *any accident in the home/* any accident in the nursing home;
g) *any allegation of misconduct by the registered person or any person who works at the home/* any allegation of misconduct by the registered person or any person who works at the nursing home.

131. It is striking that in the light of harms arising from resident-on-resident "altercations" – some of which resulted in injuries - there are so few references to the RQIA in the documentation shared with COPNI and the DH. Not all of the 10 references to the RQIA in the information submitted to COPNI concerned notifications. There are only three references to the RQIA in materials compiled by the Office of Social Services dated February and August 2015 and January 2017. These concern a resident-on-resident "altercation. Protection Plan in place. RQIA and family informed. No serious harm." Another concerned two residents "found in a bedroom," one of whom was in a state of undress. It was noted that there was a "Risk Management plan in place. Family were informed and RQIA." Finally, it was noted that there was "no RQIA notification completed in respect of [a resident's] injury of unknown origin."

132. In correspondence from the HSCB to the Review Team during August 2019, it was noted of the interface between adult safeguarding and the RQIA:

> *Adult safeguarding is itself a complex system, which operates within a further complex system made up of a very diverse range of stakeholders, interested parties and providers. Within that complexity, it is highly likely that identified strengths in one area of the system are potentially also shortcomings within a different part of the same system. So, for example, the strength of RQIA in setting and monitoring the application of standards and regulations can become a shortcoming when one part of the system experiences that monitoring as either unhelpful or inadequate. Similarly, a strength of the current system is that adult safeguarding is clearly identified as everyone's business. However, in a health and care system under significant pressure, that can be interpreted as someone else's responsibility…*
>
> *NIASP's work with RQIA is shaped primarily by the strength of having an independent regulator who has the authority to require and enforce improvement on all providers. However, the shortcomings of the current arrangements mean that at times RQIA appears reluctant to use these powers in support of adult protection activity…*

[49] *The Northern Ireland Ambulance Service Calls to Registered Nursing and Residential Homes in Northern Ireland 2017/18: Data Summary Review* notes that during 2017-18, the total number of notifications was 15,847. RQIA has clarified that this figure includes notifications in addition to those concerning serious injuries.

At present, HSC adult safeguarding teams do not have automatic right to see the records of individuals living in care home settings e.g. administration of medicines.[50] This information is, however, available to RQIA. Whilst recognising the importance of individual confidentiality and the provisions of the data protection legislation, it would nevertheless be helpful for clarity to be provided on the limited circumstances where adult safeguarding practitioners can access individual resident records.[51]

POINTS TO CONSIDER – Learning and Change

- ✓ The regulatory requirement to notify the RQIA of 'any event' or 'any accident' would suggest that all adult safeguarding referrals, adverse incidents and events resulting in Quality Monitoring should be known to RQIA.
- ✓ The basis on which notifications to the RQIA lead to its intervention is unclear from the information shared with the Review Team.

How the system worked at other care homes

133. Following the publication of *Home Truths* the DH detailed a series of measures concerning care home standards.[52] These were:
    - *An independent review of actions by the HSC system in relation to care failings at Dunmurry Manor, with a view to identifying lessons for the future. This will be in addition to the formal HSC response to the Commissioner's report.*
    - *A workshop event involving HSC bodies to address concerns around Dunmurry Manor and care home provision generally – the aim of this will be for lasting improvements and lessons to be embedded into the HSC system. Patient and family voices will be represented at this workshop.*
    - *A scoping review on potential options for additional sanctions for private sector care home providers and companies responsible for serious failings.*
    - *A public campaign to clarify and build awareness of how care home residents, families, staff and other concerned citizens can raise concerns and make complaints.*
    - *An audit of safeguarding investigations in relation to care homes operated by the independent sector.*[53]
    - *Investment in improvement, recognising that, while vitally important, regulation and inspection will not deliver better care by themselves. In this financial year, £325,000 has been allocated to support nursing in-reach from Trusts to care homes. This means*

[50] This statement is contradicted by the SEHSCT which cites the relevant clauses of the Trusts' contracts: ***23.2*** *The Provider must ensure that all information produced in the course of this Contract or relating to the Contract is retained for disclosure and must permit the Trust to inspect such records as requested from time to time.* ***32.2*** *The Provider shall grant to the Trust or its authorised agents, including RQIA, any other Regulatory Body, internal and external auditors and NIAO, such access to those records in relation to the Contract as they may reasonably require*

[51] Correspondence from the HSCB to the Review Team

[52] https://www.health-ni.gov.uk/news/department-health-details-series-measures-care-home-standards (accessed 1st July 2018)

[53] Although the audit work is separate from that of the Independent Review Team, both work streams have shared information and reflections

Trust identified nurses will work with and support the nursing and residential care home staff to look after all the needs of residents.

- *Additional funding of £80,000 will support further enhanced clinical skills to meet complex nursing care needs in nursing homes.*
- *A new senior nursing post at the Public Health Agency is being established, dedicated to working with independent sector nursing homes and acting as a central point for the HSC to enhance quality and safety of care for patients and residents.*
- *Identification of a dependency tool to help ensure appropriate staffing levels for nursing homes. This is the latest stage of the roll-out of Delivering Care, the DH's policy on safe staffing.*
- *A measurement framework for nursing care which has been devised and tested in acute hospital wards will be reviewed for nursing homes. It will include eight key indicators that measure the impact of nursing care.*
- *The DH will support implementation of initiatives aimed at improving the quality of life for people living in care homes such as the My Home Life initiative.*
- *The DH has also recognised the need for long-term transformation of adult social care, as underlined in the expert panel report published in December.[54] A project team is taking this reform agenda forward with a carers' panel being recruited. The next phase will include a far-reaching public debate, highlighting the major challenges for policy makers and society as a result of demographic changes, investment needs and the vital importance of staff recruitment, retention and development. The public concern currently evident on care home provision provides further evidence of the need for change.*

134. This position would be endorsed by families who seek to remedy the bleak experience of their relatives in care homes and long stay facilities because poor and neglectful care is not the sole preserve of residential and nursing homes. What is consistent across settings such as DMCH, Muckamore Abbey Hospital – which was subject to an identical safeguarding system - other hospitals such as Winterbourne View[55] and Whorlton Hall[56] is the disbelief of relatives that the harms endured are neither rare nor occasional; there was no credible risk management; and no one took account of (i) the wide discrepancy between their hopes for care and support and the experience of their relatives; (ii) shameful practices including callous treatment; and (iii) the disquieting behaviour of managers and staff.

135. In preparing this Evidence Paper the Review Team reflected that there appeared to be a perception of residential care and nursing homes as providers of medical care in sub-acute medical settings. This is contrary to most people's understanding of a "care home" because it casts older people's requirements solely in physical health terms. In visits to other care

[54] This refers to Kelly, D, and Kennedy, J. (2017) *Power to People: Proposals to reboot adult social care and support in N.I. – Expert Advisory Panel on adult care and support* Belfast: Department of Health

[55] Flynn, M. and Citarella, V. (2012) *Winterbourne View Hospital: A Serious Case Review* South Gloucestershire Safeguarding Adults Board https://www.southglos.gov.uk/news/serious-case-review-winterbourne-view/ (accessed 15 August 2019)

[56] https://www.bbc.co.uk/news/uk-england-tees-48585903 (accessed 15 August 2019)

homes[57] across Northern Ireland, care staff have described practices with bewildering consequences. For example, care staff are advised that information-posters must be displayed.[58] One resident who was terminally ill was required to move from a room in which they had lived for many years to one in another part of the home because they required "nursing."

136. Discussion with professionals and preliminary feedback from DH's file audit suggests that the poor standard of record keeping at DMCH was replicated at some other care homes. The fault line between the safeguarding policy and procedures in which complaints became "mixed up" with safeguarding is confirmed. Similarly, the distinction between a "protection plan" and a "care plan" is unclear in resident's files. A typical response to a resident's falls, for example, was a "protection plan" requiring "15-minute observations." The purpose of this is unclear since observations, per se, have no credible track record in preventing falls. A visit to one home revealed that 12 residents were subject to "30-minute observations." During challenging staff recruitment times, too much valuable staff time is expended on "observations" and form filling.
137. At DMCH, one-to-one support resulted from some adult safeguarding investigations. However, since some families reported that there were times when there were not enough staff to deliver care, the likelihood of providing either the support or "15-minute observations" was remote. Neither the purpose nor the efficacy of such observations was set out in any documentation. Such practice is questionable in contexts where families have challenged the failure to meet people's care needs.
138. The "outcomes" arising from the safeguarding process in relation to older people suggest some complacent habits of thought. For example, "no serious harm…she's got dementia." Although residents' families reported that their relatives were "frightened," there was no reference to addressing "fear" in any safeguarding responses. Few safeguarding investigations appear to be brought to a clear conclusion. Many investigations were characterised by delays and the absence of any casework with either residents or their families. Home managers and staff typically had no person to person contact with health and social care staff tasked with dealing with safeguarding matters.
139. The terms "safeguarding" and "complaints" were used interchangeably. Too many "safeguarding concerns" were subjected to protracted investigations with uncertain outcomes for individuals.
140. The picture was not a new one since in 2014, the RQIA published an *Independent review of the actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus.*[59] This was in response to a history of allegations, "concerns…whistle-blowing allegations…[and] complaints" from families, staff and relevant bodies including the DHSSPS, the HSCTs, the PSNI and RQIA since 2005. The introduction to the review noted that, *Although*

[57] Members of the Review Team had visited seven care and nursing homes in NI at the time of writing.
[58] The posters were health related – information from the Southern HSCT
[59] By Peter Gibson, Eleanor Hayes and Elspeth Rea. It was an independent review prepared under Article 35 (1) (b) of the 2003 Order.

investigations have been conducted, it is not clear, at this stage, whether all concerns / allegations were investigated - this is because there was a wide range of organisations / individuals and data sources involved (p1).

141. Cherry Tree House was registered to provide care for "Learning Disability, Mental Health Condition, Old Age and Physical Disability" (p5). The review considered:
    - 65 complaints and untoward incidents during 2005 - 2013. These concerned, *inter alia,* allegations of abuse by staff, inattentive personal care and health care, medicines management and inadequate staffing levels
    - 55 whistleblowing events during 2006 - 2013. The abuse of residents, poor care standards, and staffing matters
    - 43 RQIA inspections and three enforcement actions.
142. It was stated, *Cherry Tree House had employed, in senior management roles, staff who had left previous employment following their practice being called into question. They commented that it was too easy for staff who had been dismissed in one home to move to another and felt that there are inadequate controls in place to prevent this happening* (p11).
143. The review confirmed that there were shortcomings in the delivery of care, service commissioning, "robust and responsive regulation" and attentiveness to residents' relatives and advocates. Cherry Tree House did not consistently comply with the minimum care standards, complaints to the home were poorly managed and inspection reports did not use available "intelligence" concerning the home. Identical matters *of concern about care at Cherry Tree House were highlighted on a regular basis and where improvements were made they were often not sustained…Families and others communicated their lack of understanding in escalating complaints about the care in Cherry Tree House to external bodies* (p11-12).
144. The review was critical of the RQIA's limited use of enforcement powers given the home's consistent failure to comply with minimum care standards. Its recommendations included amending regional contracts requiring homes to report all complaints and their outcomes; information packs for prospective residents; timely feedback to complainants; a review of the Public Interest Disclosure (NI) Order 1998; preparation for RQIA inspections to include knowledge concerning complaints, whistleblowing and untoward incidents; and more effective efforts to ascertain the views of residents, families and staff during inspections.
145. In the Foreword to *Home Truths* the COPNI noted:
    In [2014] …the independent review report on the Cherry Tree Nursing Home in Carrickfergus also revealed serious shortfalls in the standard of care and the inspection regime. At the time, there were a number of public commitments made to bring about change and to implement a series of recommendations to prevent a repeat of this happening in the future. Unfortunately, the response to these recommendations has been slow and disjointed, the result being that many of the failures identified in this investigation could have been prevented

or at least managed better had the previous findings and recommendations been acted on more quickly and in full[60] (p3).

146. During August 2017, the RQIA cancelled the registration of Ashbrooke Care Home, Enniskillen which was operated by Runwood. The Press Release of 21 August 2017, stated that the RQIA's action was "in response to safeguarding concerns received by RQIA" on 15 August. An urgent, unannounced inspection identified *systemic care failings and concerns in relation to the management of the home…a serious risk to the life, health and wellbeing of all those living at Ashbrooke Care Home, and…assurances from the provider were not sufficient to address the risks.* Runwood claimed that it did not received prior notification of the closure. By 24th January 2019, the home was to be re-opened as Meadow View Care Home. This has been challenging for the families of residents at DMCH in the light of their endeavours to improve their relatives' circumstances.

147. In the "Lessons to be Learned" section of *Home Truths,* COPNI stated:
What was noteworthy in the evidence gathering was that several RQIA witnesses who gave evidence to the investigation said that "Dunmurry Manor is not the worst." The Commissioner is concerned that there is a degree of desensitivity to what are acceptable norms in a care home. It is clear that RQIA inspectors did not see the extent of the problems at Dunmurry Manor and that if they had seen the totality of the evidence provided to the investigation it is hoped that the action taken would have been different (p150).

POINTS TO CONSIDER – Learning and Change

- ✓ "Home" has many meanings which are tied to the way we live. It is a functional space of nourishment and domestic rituals. It is where we sleep, wash, dress, eat, sit and talk. It is a place of storage. Our homes support our identities and reflect who we are. It is possible to align our understanding of home to the environmental complexities of homes providing people with care, support and/ or nursing.
- ✓ There is immense value in simplifying records.
- ✓ Numerical safeguarding referral data is limited in the absence of explanatory context, e.g. a single person may be associated with many incidents. There is more merit in considering: numbers against standards; objective outcomes; subjective outcomes; and individual stories.
- ✓ The RQIA's role in safeguarding is unclear to practitioners. Similarly, the interface between complaints, safeguarding and notifications is difficult to understand.
- ✓ The public has diminishing sympathy with the promise that 'lessons will be learned' and with 'apologies' from public officials. Learning is integral to a functioning whole system rather than a part of belated breakdown repair.

[60] Progress concerning these and other recommendations were tracked by the DH and the RQIA and respective HSCTs confirmed that the majority had been accepted and enacted.

Section D: Partnerships in Adult Safeguarding

How Adult Safeguarding is experienced

> "Safeguarding shouldn't be overwhelming people with paperwork"
> "There has to be partnership and collaboration in safeguarding. It cannot be achieved through cumbersome systems and processes"
> – contributors to the Adult Safeguarding Workshop – 12 March 2019

148. The March 2019, adult safeguarding workshop confirmed that adult safeguarding's documentation/ template forms are cumbersome and ineffective. Professionals immersed in safeguarding activities are see-sawing between capitulation to different processes and attention to the care and treatment of individuals. They would favour: "less complex policies and guidelines// …more staff to work with people instead of form-filling being stuck behind a computer screen// and less [complexity] re criteria,"
149. Professionals reported being exercised by the roles and responsibilities associated with adult safeguarding, most particularly in the light of different approaches across the five HSCTs. In the absence of a regional approach, the following observations and changes were proposed:
    - "Why is adult safeguarding seen as the be all and end all?
    - There has to be partnership and collaboration in safeguarding. It cannot be achieved through cumbersome systems and processes.
    - We're at a point where everything is safeguarding and we're over-analysing.
    - We have to be able to evidence what we do – not just by referring to processes.
    - We have to be person-centred and not driven by bureaucracy and paperwork that takes us away from good care planning.
    - It's unfortunate that it has taken these scandals to turn attention to safeguarding's systems including social work's and nursing's profile.
    - We should be looking at good case management and fulfilling this to the best of our ability. We want competent and confident case managers. There are multiple and complementary roles in teams.
    - We want a consistency of practice across the Trusts."
150. Professionals identified the following as hurdles to adult safeguarding practice, *If only*:
    - "it was well understood and implemented uniformly on a national level.
    - Social workers applied a more systematic approach to practice where they are more skilled in asking the right question – we might have many fewer safeguarding incidents.
    - [there was] a better understanding of whistleblowing policy by staff members/better support.
    - Professionals were less fearful of safeguarding processes.
    - It felt less isolating and exposing so that practitioners felt safer keeping service users safe.
    - All staff/everyone treated each other [well].

- [We knew] how to disseminate learning from investigations so other facilities don't make the same mistakes.
- [There was] support from RQIA."

151. The workshop confirmed that professionals' responsibilities concerning adult safeguarding are contested. They would favour:
    - "One team [investigating] the cases within the Trust – [it is] not the same across all Trusts
    - [Clarity concerning] staff roles and responsibilities in the community/nursing teams
    - Everyone recognised it was their role and not just social workers and nurses."
152. There was consensus that adult safeguarding practice should be underpinned by legislation, for example, [If] "We had a legislative framework to inform and underpin practice – [it] would vastly support and guide Adult Protection and Safeguarding".
153. Participants want to understand the interfaces between adult safeguarding, contract monitoring and the work of the RQIA. They want the procedures to be "standardised" across the HSCTs less confusing and the learning from investigations disseminated. There was consensus that the use of familiar language would make the practice less daunting for everyone. There is a real appetite for change and for a planned programme of reform which engages everyone.

The role of Northern Ireland Safeguarding Adults Partnership (NIASP)

154. The 2015 Policy describes NIASP as*, a regional collaborative body led by the Health and Social Care Board. It is supported in its work by all its constituent members who have made a commitment to adult safeguarding. The membership is drawn from the main statutory, voluntary, community, independent and faith organisations involved in adult safeguarding across the region and includes representation from service providers and users. The NIASP is responsible for promoting and supporting a co-ordinated and multi-agency approach and for creating a culture of continuous improvement in adult safeguarding practice and service responses. The NIASP strategy promotes ownership of adult safeguarding issues within all partner organisations and across all professional groups and service areas…Each member representative is accountable to their employing organisation and should be of sufficient seniority to bring adult safeguarding issues to the attention of NIASP and to make decisions on behalf of their organisation. Each representative should ensure that that any actions and decisions taken by the NIASP are shared and implemented as appropriate within their organisation* (p16-17).
155. *The HSCB has lead responsibility for the effective working of the NIASP, which is chaired by the Director of Social Care and Children's Services, or a nominated deputy. The Chair ensures that safeguarding matters are brought to the attention of the appropriate Directors in the HSCB and the Public Health Agency (PHA). The Chair is accountable to the HSCB and is responsible for ensuring that there are robust governance arrangements in place and compliance with the HSCB's responsibility for Delegated Statutory Functions* (p17).

The role of Local Adult Safeguarding Partnerships (LASPs)

156. The 2015 Policy states of the LASPs that they, *are located within and accountable to their respective HSC Trusts. Their role is to implement the NIASP Strategic Plan, policy and operational procedures locally. Each LASP has responsibility to promote all aspects of safeguarding activity in its area and to promote multi-disciplinary, multi-agency and interagency cooperation, including the sharing of learning and best practice. They will be visible within, and engage locally with, communities to raise the profile of adult safeguarding. The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB. Each partner organisation should be represented at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Each representative should be sufficiently senior to represent his/her organisation's views, to make decisions on its behalf and to ensure that safeguarding issues are dealt with in line with the organisation's established governance arrangements. Each representative should ensure that any actions and decisions taken by the LASP are shared and implemented as appropriate within their organisation* (p17).

The Joint Approach to Adult Safeguarding

> "There isn't a safeguarding outcome, it's just a process. It's a duplication of incident reporting but safeguarding has taken over. It takes 45 minutes to complete the forms then 20 minutes for me to screen them out" – a nurse

157. *The Protocol for Joint Investigation of Adult Safeguarding Cases* was published by NIASP during August 2016. It is intended to be read with the policy and operational procedures. Its Introduction states that the "Joint Protocol:"[61]
    - *…will provide clarity in respect of the roles and responsibilities of adult protection services where the nature of the harm to the adult in need of protection constitutes a potential criminal offence* (p5).
    - [aims]…*to ensure that the adult in need of protection is supported in a manner which upholds his/her rights, in particular their right to equal access to the criminal justice system and to prevent further abuse through a collaborative multi-agency partnership* (p8).
    - *…aims to provide a framework within which HSC Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm/abuse constitutes a potential crime* (p6).

[61] It is understood that the Joint Protocol is under review within the PSNI. No revisions have been made available to the Review Team.

158. The Joint Protocol identifies the "roles and responsibilities of key agencies." For example, the five HSCTs have "Key personnel" with lead responsibility for adult safeguarding, that is, the DAPOs, Investigation Officers (IOs) and Specialist ABE [Achieving Best Evidence] Interviewers. The out of hours RESWS will assume the role of the DAPO in emergencies. The Central Referral Unit ("CRU"), the regional PSNI centre for all referrals associated with abuse, exploitation or neglect will determine which part of the service will lead a criminal investigation. The PSNI will investigate alleged offences. If an identifiable person has committed an offence a file will be forwarded to the PPS. The latter makes prosecution decisions such as the charges to be made and decides whether criminal proceedings should be continued.
159. The PSNI received nine reports from DMCH staff. These concerned missing persons (4); *patient on patient assaults* (2); theft (1); criminal damage (1) and one which resulted in a *safeguarding investigation*. It received two reports from relatives concerning a *patient on patient incident* which resulted in no further action; and one which was reported to the PPS. The latter directed "no prosecution."[62]
160. The Joint Protocol sets out the "reporting and referral arrangements" which are conflated to "referral/report" in the text. Since people's "views and wishes are paramount," their consent should be sought. The HSCTs' Adult Safeguarding Champions *should ensure that a referral to HSC Trust Adult Protection Gateway Service is made*. The PSNI may make "referrals/reports to HSC Trusts," however,
    - *Where a police officer decides that a referral to the HSC Trust against the expressed preference of the individual involved is appropriate the rationale for the decision must be clearly recorded* (p14).
161. With reference to the RQIA:
    - *RQIA's remit…involves prevention, safeguarding and protection of adults at risk of harm and adults in need of protection. With regard to the Joint Protocol RQIA are a key partner in relation to investigations and protection planning in all regulated services* (p12).
    - *Where there is a concern regarding an individual or group of individuals, RQIA should consider whether this has been caused by abuse, exploitation or neglect. In these circumstances a report to the relevant HSC Trust should be made…RQIA will make an immediate report to the PSNI if there is an imminent risk to any service user* (p15).
162. The RQIA made a single referral directly to the PSNI regarding DMCH. This was based on a report from the relative of a resident.[63]
    - *Where an incident relates to a regulated service RQIA will attend adult protection strategy meetings and case discussions to contribute to joint agency information sharing and joint agency action planning* (Appendix 12 notes on p86).
163. The Joint Protocol states that, *the role of the HSCT DAPO is to screen the referral and any other available information to ensure that all relevant HSC processes are implemented as applicable* (p19). A "Joint Agency Consultation" determines "the most appropriate course of action" (p23). This may be a single agency, HSCT investigation, a single agency PSNI investigation or

[62] Correspondence from PSNI dated 16 September 2019.
[63] Correspondence from PSNI dated 16 September 2019.

no further action, for example. Work was undertaken during 2019 to revise the Joint Protocol. However, this was limited to ensuring consistency between the policy, the procedures and the Protocol.[64]

164. The document includes 50 pages of appendices, 18 of which are referral forms. Appendix 7 cites the Human Rights Act 1998 and lists the rights within the European Convention for the Protection of Human Rights and Fundamental Freedoms.[65]

POINTS TO CONSIDER – Learning and Change

- ✓ The adult safeguarding template forms are overloaded.
- ✓ Responsibility for undertaking an adult safeguarding investigation should be transparent and known across the region.
- ✓ The rights of the resident and their representative need to be paramount.

A Memorandum of Understanding

165. During March 2013, a *Memorandum of Understanding* was published. Its full title is *Investigating patient or client safety incidents (Unexpected death or serious untoward harm): Promoting liaison and effective communications between Health and Social Care, Police Service of Northern Ireland, Coroners Service for Northern Ireland, and the Health and Safety Executive for Northern Ireland.* The front cover's logos are those of the PSNI, DHSSPS, HSENI and the Courts and Tribunals Service.[66]

166. The document's Foreword notes:

The Memorandum is intended to help:

- *Identify which organisations should be involved and the lead investigating body;*
- *prompt early decisions about the actions and investigation(s) thought to be necessary by all organisations and a dialogue about the implications of these;*
- *provide an understanding of the roles and responsibilities of other organisations involved in the memorandum before high level decisions are taken;*
- *ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned*. (p1)

167. In addition, the Foreword notes that the memorandum defers *to the overarching principle of the protection and preservation of life*.

168. The Memorandum confirms that: its "principles and practices" are applicable to "locations where health and social care is provided;" some accidents to patients or clients are required to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997 (RIDDOR); *HSE organisations have a responsibility…to ensure the safety and well-being of patients or clients and staff and to investigate when things*

[64] The Southern HSCT notes that clarity is required concerning the strategic direction of adult safeguarding

[65] In this context, the most relevant Articles are 2: the right to life; 3: right not to be subjected to torture, inhuman and degrading treatment; 5: right to liberty; 6: right to respect for private and family life; and 14: and right not to be subjected to discrimination.

[66] http://www.hscbereavementnetwork.hscni.net/wp-content/uploads/2014/05/memorandum-of-understanding_investigating_patient_or_client_safety_incidents.pdf (accessed 21st July 2019)

go wrong…In discharging this responsibility the HSE organisations must have policies and procedures…[and] ensure that the requirements of the memorandum operate effectively alongside procedures and protocols established in …the protection of vulnerable adults (p4).

169. The Memorandum states that a spur to the involvement of the PSNI should be *evidence or suspicion of gross negligence and/ or recklessness…including as a result of failure to follow safe practice or procedure or protocols* (p5). It adds that, *Although HSENI is responsible for enforcing work-related health and safety legislation in a large variety of settings including hospitals and nursing homes, District Councils have this responsibility where the main activity is the provision of permanent or temporary accommodation e.g. statutory residential homes and other residential homes* (p5).
170. The document states, *Coroners have a responsibility under the Coroners Act (Northern Ireland) 1959 to investigate the cause and circumstances of deaths in cases reported to them that appear to be unexpected or unexplained, a result of violence, the result of an accident, a result of negligence, or a result of any cause other than natural illness or disease" (p5). Medical practitioners have a statutory duty to report such deaths, including for example:*
    - *"…the death of a patient or client who had an accident in the health or social care environment;*
    - *the death of a patient or client where there is an allegation of negligence or of a medical or nursing mishap*. (p12)
171. During August 2019, the Review Team was advised that,
    There were no Inquests relating to the deaths of any residents who died at Dunmurry Manor Nursing Home during the period 16 July 2014 to March 2018. A total of 9 deaths relating to residents at Dunmurry Manor Nursing Home have been reported to the Coroners Service. Of these five residents died in hospital and the remaining four residents died in the Nursing Home itself…[During] 1 August 2018 to 31 July 2019 inclusive…5% of inquests related to persons aged over 75 years and 2% of deaths occurred in either residential care or nursing homes for older people. [67]
172. The Memorandum states that: *Other organisations may also have a role in investigating patient or client safety incidents at local or national level. These include the HSC Board/ Public Health Agency, Regulation and Quality Improvement Authority (RQIA), the Northern Ireland Adverse Incident Centre (NIAIC), and the professional regulatory bodies* (p6).
173. The Memorandum confirms that where more than a single investigation is likely: *In cases where more than one organisation may/ should have an involvement in investigating any particular incident, it is the responsibility of the HSC organisation to report to each of these organisations as appropriate…When organisations are notified of an incident, it is their responsibility to consider if the incident should be investigated by their organisation, or reported to any of the organisations who are signatories to the memorandum. If several organisations are involved they should consider if a Strategic Communication and Decision-Making Group (the Group) meeting is required…The meeting will allow* [*inter alia*]

[67] Correspondence from the Coroners Service for Northern Ireland dated 29 August 2019.

- *organisations to set out their needs so that actions can be agreed that do not prejudice the work of each organisation;*
- *clarification of the role of individual organisations involved;*
- *determination of the appropriate body with primacy responsibility to investigate and take the lead in coordinating with others* (p6).

Where possible the statutory investigating bodies will come to an early view about the nature of the incident and where responsibility for any future investigation lies (p7).

174. The Memorandum contains eight Appendices: *Reporting deaths to the Coroner; Reporting of Injuries, Diseases and Dangerous Occurrences (Northern Ireland) Regulations 1987* [68] *(RIDDOR); Reporting requirements on HSC organisations under the Memorandum; Other Useful Contacts; Contacting Relevant Organisations; Contacting Professional and Regulatory Bodies; Other Related Documents; and Members of the Review Working Group.*
175. Appendix 3: Reporting Requirements on HSC Organisations under the Memorandum notes: *Until 1st May 2010 HSC organisations were required to routinely report Serious Adverse Incidents to the Department of Health, Social Services and Public Safety. From this date, revised arrangements for the reporting and follow-up of Serious Adverse Incidents (SAIs), pending the full implementation of the Regional Adverse Incident Learning (RAIL) system, transferred to the Health and Social Care Board (HSCB) working in close partnership with the Public Health Agency (PHA) and the Regulation Quality Improvement Authority (RQIA)* (p16).
176. The Appendix states that the HSCB issued a procedure for the *Reporting and Follow-up of Serious Adverse Incidents* for implementation on 1 May 2010. The criteria which determine what constitutes a SAI include [*inter alia*]
    - *serious injury to, or the unexpected/ unexplained death…of a service user…*
    - *Unexpected serious risk to a service user…*
    - *Serious assault (including homicide and sexual assaults) by a service user: On other service users…*(p17).
177. The RQIA *can receive reports of deaths or serious incidents involving patients and clients in relation to (i) Regulated sector services (ii) Mental Health services and (iii) Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)* (p19-20).

POINTS TO CONSIDER – Learning and Change

- ✓ There are relatively few inquests concerning older people who were accommodated in residential and nursing homes.
- ✓ The HSENI is focused on facilities issues such as equipment failure and legionnaires disease. It does not address the the clinical care or professional judgements made about the care of residents.

[68] This is an error. It should read 1997

A Regional Approach to Adult Safeguarding

"I find the processes really difficult across NI" - contributor to the Adult Safeguarding Workshop – 12 March 2019

178. The *Ten thousand more voices*[69] project's aim:
    - *…is to identify how the Adult Safeguarding process can be improved to ensure the service user's experience is rights based, empowering, consent driven and as person centred as possible* (p3).
179. The title of the report is potentially misleading since it is based on "167 surveys received from clients" and "27 staff experiences." The 167 adults:
    - *…included all adults who had experience of the adult protection process from the point of strategy planning[70] and were closed to all protective interventions during the period June 2017 - March 2018* (p3).[71]
180. The report conveys a broadly positive account of people's experience of the safeguarding process.[72] However, it is noted that it is *regionally consistent in terms of the benefits of the project…uptake remains regionally lower than expected* (p27). It is difficult to gauge the type of safeguarding challenges faced by staff and/or the people for whom they had responsibility. The highlighted "themes for service improvement" include "communication and being kept informed;" and "professional timeliness."
181. Surprisingly there is a single reference to the "reduction of paperwork" (a plea from one of the 27 members of staff). This is remote from the strongly expressed views of practitioners at adult safeguarding workshops. These were critical of the failure of the policy and operational procedures to credibly connect; of the proliferation of templates and approaches; and of its process-driven nature. Yet *10,000 Voices* does not propose that there is scope for the wide-reaching overhaul of all documentation concerning the adult safeguarding processes which was a resounding theme of the workshops of February, March and July 2019. These were characterised by criticism of the policy and operational procedures.
182. *10,000 Voices* recommends, inter alia, that:
    - *Keyworkers collecting experiences should view 10,000 Voices adult safeguarding service user and carer feedback as a post investigation opportunity for meaningful therapeutic intervention* (p28-29).
183. Two of the five questions asked by the *10,000 Voices* survey hinge on satisfaction:

[69] Health and Social Care Board and Public Health Agency (2018) *Ten Thousand More Voices Project Experience of Adult Safeguarding: Final Evaluation report*, June

[70] The Operational Procedures and the Joint Protocol refer to "strategy meetings" which are defined: *in complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts*

[71] The Southern HSCT have clarified that the title is "Experience of Adult Safeguarding." The Methodology is the overarching 10,000 More Voices Project. There are multiple areas of service delivery across Health and Social Care which have used this project to learn from service user and carer experience

[72] The Southern HSCT note that the Final Adult Safeguarding report was approved by PHA during November 2018

- *To what extent did you feel satisfied with how the safeguarding investigation was carried out?*
- *To what extent were you satisfied with the outcome of the investigation?*

"Satisfaction" is unreliable as an indicator of improvement or driver of service responsiveness.[73] The downside of questions about satisfaction and satisfaction surveys is that they are hardly pertinent to people who use a service unwillingly. Care home services are often "distress purchases," that is, they are made at a time when people are vulnerable and disempowered. Surface satisfaction responses such as "I'm fine// It's ok" may mask deep distress and resentment which is unlikely to be elicited in a brief interview or by a questionnaire. Some people are (a) guarded in expressing their opinions due to their reliance on the goodwill of staff and/ or (b) have become accustomed to poor services; and matters of critical importance such as being treated with dignity and respect, are unlikely to be reflected in measures of satisfaction.[74]

184. For example, the efforts to gather people's experience of safeguarding during June 2019 at Muckamore Abbey Hospital were the result of the *10,000 Voices* project's questions. They were described by staff as "too complicated" for people with compromised cognitive skills.
185. The "recommendations by the PSNI"[75] state:
    - *In general, service users have reflected that they have had a positive experience with police. From the project some felt the criminal justice process was too protracted. There is a need for officers to give clear information on the investigation, and the time it may take to reach an outcome. Consideration should also be given to clarifying service user/carer understanding of the information given to them, especially after a traumatic event. Investigating officers should also ensure there is ongoing engagement to keep service users/ carers updated, manage expectations and share outcomes* (p29).
186. *10,000 Voices* is silent about the COPNI investigation. Although the report concerning DMCH was published during June 2018, the events at the home subsequently received a great deal of coverage in the media. The formal publication of *10,000 Voices* (during November 2018) was not taken as an opportunity to set out the identified learning concerning DMCH.
187. The NIASP website[76] identifies four "key priorities":
    - *Determining the regional strategy for safeguarding vulnerable adults.*
    - *Developing and disseminating guidance and operational policies and procedures.*
    - *Monitoring trends and outcomes.*
    - *Monitoring and evaluating the effectiveness of partnership arrangements.*
188. To do full justice to the complexity of delivering the best possible services, widespread involvement in learning and problem-solving is required.

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[73] Horner, L. and Hutton, W. (2011) Public Value, Deliberative Democracy and the Role of Public Managers. In J. Benington and M. H. Moore (Eds.) *Public Value – Theory and Practice* Basingstoke: Palgrave Macmillan

[74] Flynn, M. and Ward, L. (1994) What matters most: disability, research and empowerment. In M. H. Rioux and M. Bach (Eds.) *Disability is not measles: new research paradigms in disability* Ontario: Roeher Institute, York University

[75] It is not explained how widely this position was canvassed within the PSNI.

[76] http://www.hscboard.hscni.net/niasp/ (accessed 27 May 2019)

189. The “trends and outcomes” are derived from the number of investigations (arising from recorded referrals to adult safeguarding), trends in Care and Protection Plans and Joint Protocol investigations across the HSCTs. Scrutiny of the recorded referrals and investigations at DMCH suggests that inconsistency and misunderstanding prevail. There is no evidence of the monitoring or evaluation of partnership arrangements (the NIASP Annual Report April 2017 - March 2019 refers to the Domestic and Sexual Violence Strategy and a peer support network for the Adult Safeguarding Champions). The different and disparate ways of responding to allegations of harm and the unanticipated volume in documentation across the HSCTs is acknowledged by professionals. The IT systems of different HSCTs and agencies compromise the timely exchange of safeguarding related information.

190. Although monitoring and evaluation are often used interchangeably, they refer to distinct processes and have different objectives. It is not clear from the policy, operational procedures or Joint Protocol how the NIASP and LASPs “partnership arrangements” impact on adult safeguarding practice or generate favourable outcomes. This is not a coded way of suggesting that there is no role for partnerships in adult safeguarding. Participants at the workshops were highly motivated to improve “safeguarding” and to learn from its achievements and disappointments. Such learning is enhanced when a variety of perspectives are encouraged to assess progress and seek better ways forward.

POINTS TO CONSIDER – Learning and Change

- ✓ The 2015 policy has not achieved the stated aim of having a regional approach.
- ✓ The profile, authority and influence of the Health and Social Care Board has diminished since its closure was announced during 2015.
- ✓ The membership of the NIASP does not include the Northern Ireland Social Care Council.
- ✓ The emerging role of “contextual safeguarding”[77] merits consideration.

[77] https://contextualsafeguarding.org.uk/about/what-is-contextual-safeguarding (accessed 3rd February 2019)

Section E: Learning and Change – proposals for action

> "Safeguarding is one-way – the Trusts to care homes - and yet major issues in the Trusts are unrecognized" – participant at Adult Safeguarding workshop
>
> "There's no engagement with the sector, only reporting requirements. // Who in the system supports homes? // We have to share lots of information and we're not getting anything back! // There's a post-COPNI effect of over-diligence. // Too much monitoring and inspections. // Too many forms, monitoring visits – are they duplication? // When there's a concern then everyone descends on the home and swamps the Manager. // The process and investigations are unbelievable. "Pop-sock gate" [was how one home described a safeguarding investigation about] a resident being assisted to put a pop sock on when the elastic snapped and hit her leg. // The regional safeguarding policy is not being followed by the Trusts. // Adult safeguarding is a disgrace. // Safeguarding? Waste of time! // [We want] clarity about the monitoring role of Trusts; [an] evaluation of policy, guidance, data collection and stats; a single portal for reporting incidents; credible investigation and review processes; one approach; focus; consequences and a clear process for care homes when we are not happy with Trusts' approaches" – Care home owners, providers and staff working session 15 and 20 May 2019

Analysis

Overview

191. This Evidence Paper has drawn on an incomplete jigsaw of sources to build on COPNI's findings concerning the experience of older people at DMCH. Whilst there are undoubtedly more pieces, the Review Team can share the emergent picture in terms of learning and proposed change. The analysis draws on the POINTS TO CONSIDER identified throughout the Paper. It seeks to offer opportunities for learning at policy, procedural and practice levels for adult safeguarding partners, the organisations and practitioners involved. It brings forward some pragmatic proposals for change – ones with the potential (i) to contribute to implementing the COPNI recommendations concerning adult safeguarding and human rights; (ii) to be welcomed by organisations, professionals and managers who participated in the Review's working sessions; and (iii) to be recognised by families as the type of practical actions that will reduce the likelihood of harm and neglect of their relatives living in care homes.
192. The analysis opens with a summary of learning from research (see Appendix C). It considers the purpose of the adult safeguarding system - its values, principles and the human rights' background. It goes on to look at governance, leadership and management and closes with an analysis of the main practice points around safeguarding in care homes including the communal context, risks, admissions practice, complaints, care management and the use surveillance technology.
193. It seems that safeguarding practice with care home residents is founded on doing things right rather than doing the right thing. That is, procedures typically prevail over residents' best interests. There are examples of time and effort invested in incorrect and disparate activities due to divergent safeguarding practices across Health and Social Care Trusts. The HSCTs apply

different processes to similar scenarios, resulting in "investigations" and "monitoring" at the expense of care management. Forms and records are inconsistent between HSCTs and often not fully completed. Not enough credence is given to basic "fact-finding" by care homes and/or practitioners with lead responsibility when assessing a referral. It appears that an adult safeguarding referral is the standard response to every incident, error, mishap and conflict in care homes.

194. Remedies require a contextualised approach to preventing harm and neglect. All agencies should fulfil their remit, exercise their powers and deploy their resources to protect care home residents. Practitioners must use their knowledge, skills and experience to support people whilst recognising the risks and realising the benefits of living in a care home community.
195. Much safeguarding practice is premised on the conviction that people must be kept safe at all costs. There is a gap between this conviction and the (i) methods invoked, (ii) consideration of individual outcomes, (iii) use of this information and (iv) research to shape future practice. In the absence of such scrutiny, safeguarding is a blunt and heavy instrument in care homes. It appears that an adult safeguarding referral is the standard response to every incident, error, mishap and conflict in care homes. It appears that safeguarding is the only tool within reach. There are better ways of producing more of what is required and less of what is unhelpful.

Learning from Research

196. Adult safeguarding resides in the territory of errors, oversights and unheeded warnings. It is not new. Recorded history of "institutional care" confirms that some adults' lives have always been characterised by the destructive impacts of cruelty, violence, neglect and fear of harm.[78] In 2019, adult safeguarding remains an untidy topic which has grown to take in domestic violence, hate crime and Female Genital Mutilation, for example.
197. It is a difficult topic because it requires us to consider the distress of people with limited articulacy, matters of sexuality and the violation of norms in our homes – where we should be most safe. Yet accurate definitions continue to preoccupy professionals because if we are unclear about the subject we face, our work is unfocused. Appendix C sets out a research context. This is informed by "givens" such as: abuse is destructive and it steals lives; it is well-served by minimization and denial; its consequences reach beyond human suffering; and it exacts tolls on services which are tasked with the processes of (i) assisting individuals and their families to recover (ii) enabling services to enter into restorative partnerships and (iii) learning about effective prevention as well as how individuals and organisations surmount abuse.
198. The summary confirms that there is little research concerning the abuse of older people in the UK. With reference to those in care homes, what we do know is that once harm is alleged or known to have occurred, safeguarding activities are reactive and prone to disputes concerning "thresholds" or about prospective contributors to strategy discussions for

[78] For example, Abel-Smith, B (1964) *The Hospitals 1800-1948: A study in social administration in England and Wales* Boston: Harvard University Press

example. We learn that more thorough ways of assessing the suitability and personal values of Registered Managers and potential staff are required. Experienced health and social care staff – and residents' families – who visit services are attuned to "signs" that a service is deteriorating. The research indicates that any structural reform has to parallel reform at an individual level and this should always emphasise compassion and dignity over price, most particularly since care homes are increasingly regarded as providers of palliative care. Furthermore, the regulator's scrutiny in terms of improving the sector and preventing abuse has unproven effectiveness.

Purpose of the Adult Safeguarding System

199. The evidence gathered by the Review revealed that the specifics of interpretation and compliance with the spirit of the 2015 policy and 2016 procedures vary across Northern Ireland. Safeguarding responses at DMCH have shown that procedural "fixes" neither prevented nor tackled the harms to which adults were exposed. The purpose of safeguarding interventions cannot be determined from systems which have spawned new systems and requirements.
200. The Review Team endorses the Office of Social Services' position[79] that "there is real concern about the Governance [of adult safeguarding] at the Regional and Trust level." There was little consistency across the files reviewed. Forms from the Operational Procedures were typically incomplete and some were illegible. A section concerning human rights was rarely completed. The parallel processes which have developed are plagued by inconsistent recording, inadequate "investigations" and needless back-and-forth between safeguarding investigations, Quality Monitoring, Risk Management and contract compliance processes, for example.
201. Few reports concerning DMCH were made to the PSNI – a decision which was the responsibility of adult safeguarding leads and the RQIA. Typically, the views of people's relatives were sought about contacting the police. Where the COPNI report cited examples of potentially criminal acts, the Review Team could not reconcile these with PSNI activity at the home. This was of concern where the incidents of assault were indicated.
202. Adult safeguarding practice in Northern Ireland poorly served the people residing in DMCH. Attempts to advance a coordinated and multi-agency approach to the tasks of protecting and promoting the welfare of older people living in care homes using complicated procedures has failed. A Registered Manager's perceptions about the significance of certain acts are the result of prior experience, knowledge and understanding of risk-taking. DMCH was registered by the RQIA even though it had no Registered Manager. It is anomalous that evidence of inadequate attention to older people's hydration, nutrition and pressure ulcers, for example, results in vague adult safeguarding "investigations" when urgent, clinical responses are required.[80]

[79] See paragraphs, 7, 72 and 133

[80] Although SEHSCT placed nurses at Dunmurry Manor and provides training and support regarding tissue viability concurrently with safeguarding investigations to address clinical issues, this practice is not sustainable

Principles

203. The principles shaping adult safeguarding practice should be set within a **Human Rights Based Framework** and emphasise dignity, fairness, equality, respect and autonomy. They should be manageable in terms of quantity; understandable - perhaps adopting terms such as "adult protection/ keeping people safe;" and consistent if there is to be confidence in the judgement of professionals. For example, principles such as:[81]
    - Supporting people who have care and support needs to **nurture their welfare and well-being** and **reduce the risk of harm**.
    - Giving **people** at the heart of service provision an equal say in the support they receive
    - Driving service delivery through **partnership and co-operation**.
    - Promoting the **prevention** of escalating need and providing **timely assistance**.
    - Encouraging residents, family members and staff to **be involved** in the design and delivery of services – "co-production."
    - Being **accountable** to the public and to the statutory agencies from which local partners are drawn. Publication of data, trends and findings as well as plans for change, are a vital means of ensuring accountability.

    The principle of **proportionality** is fundamental to the European Convention on Human Rights.
204. The Review found that compatibility with human rights remains to be fully embedded in the practice and care of older people. It would be helpful if there was a clear statement of purpose at the point of a care home's registration, monitored through inspection by the RQIA and reported to its Board in its annual assurance process. At the time of registration and in subsequent inspections, all provider policies and Regulation 29 visits should address how the human rights of residents are working in practice.
205. Care home providers and care managers should play a vital role in promoting residents' rights. In the care setting it is the responsibility of the provider to ensure that the social care workforce receives human rights' training. Providers should anticipate being supported by NISCC, RQIA and commissioners in this endeavour.

Governance

> "…safeguarding adult reviews and their multi-agency "action plans" are not the most suitable vehicles for achieving better lives for adults with assessed care and support needs. These reviews are partial and highly variable descriptions of a complex whole – regardless of whether they concern individuals or groups of individuals in residential and nursing settings. They are no substitute for effective commissioning, professional case management, assured service providers that are precisely registered and proportionately inspected…
>
> It appears that the purpose of safeguarding has been subverted to setting out (a) what it is that providers, service commissioners, contract monitors and inspectors should be doing

[81] The guiding principles of *My Home Life* are premised on human rights.

anyway, in addition to (b) the remit, powers and enforcement resources of the organisations concerned.

… "lessons learned" are not in fact resolving anything in a permanent way. It seems to us that, despite hectoring recommendations, rarely are the systemic concerns around commissioning, the nature of the market and its regulation the subject of embedded change.[82] What is achieved is often dependent on individual champions, soon eroded by an unreceptive climate, as well as fragile and short-lived organisational memories… what reviews identify is a need to reassert the primacy of professional leadership, most particularly among social workers and nurses. In addition, such leadership is essential at the helm in social care in the guise of the Registered Manager. It is only here that lessons can be truly learned and handed on to future generations, with accountability to be readily demonstrated by people in the know rather than through reviewers." [83]

206. Good governance of a care home is about purposeful decision-making and how professionals give expression to person-centred values. It is the responsibility of leaders and managers to ensure that care homes are well-led with a statutory duty falling on the Registered Provider and its Responsible Individual.

207. The governance of adult safeguarding has been identified by research[84] has having five components:

    i. *clarity of goals, scope of activity and purposes, including shared principles, multiagency commitment and strategic leadership*
    ii. *structures, including clear divisions of responsibility and mechanisms for communication, and explicit linking between functions or activity*
    iii. *membership, including a clear rationale for inclusion of agencies, understanding of roles, responsibilities and commitments, evidence of engagement and protocols for chairing, quoracy, resource contributions and business management*
    iv. *functions, including strategic planning and operational oversight, appreciation of the difference between governance and executive management, and a strong developmental and improvement agenda which embraces audit, performance management and quality assurance*
    v. *accountability, including standards for and assessment of committee performance, clarity about decision-making authority and reporting channels and explicit links to other partnerships*.

[82] In the absence of a national database or directory, the challenge of creating sustainable change is considered in Preston-Shoot, M. (2018) *Learning from safeguarding adult reviews on self-neglect: addressing the challenge of change* Journal of Adult Protection 20 (2) 78-92 https://www.emerald.com/insight/content/doi/10.1108/JAP-01-2018-0001/full/html (accessed on 4th September 2019)

[83] Flynn, M. and Citarella, V. (2019) Connecting people's lives with strategic planning, commissioning and market shaping. In S. Braye and M. Preston-Shoot (Eds.) *The Care Act 2014: Wellbeing in Practice* London: Sage Publications, Learning Matters, 2020

[84] Braye, S., Orr, D. and Preston-Shoot, M. (2012) The governance of adult safeguarding: the findings from research *The Journal of Adult Protection* 14 (2), 55-72

208. NIASP states[85] that it *prepares an Annual Report on activity and key challenges and/or achievements in relation to prevention, protection and partnership working. The Annual Report also contains a review of the action plan for the previous year and sets out the NIASP action plan for the incoming year. NIASP Annual Reports, once approved by the HSCB Governance Committee, are submitted to the Department of Health and the Department of Justice and placed on the NIASP webpage of the HSCB website. NIASP contributes to, and works within, the framework of the planning, commissioning and performance framework established by the HSC Board in partnership with the PHA and has regard to the requirements of partner organisations. In addition, HSC Trust activity in relation to adult safeguarding is a standard agenda item for Delegated Statutory Functions meetings between HSC Trusts (Adult Services) and the Social Care and Children's Directorate of the HSCB. A summary report on HSC Trust adult safeguarding activity and performance is an integral part of the general overview report on HSC Trust performance in relation to Delegated Statutory Functions which is submitted to the Department of Health.*

209. With reference to NIASP's membership, it notes:
At the time that NIASP was first established, letters were sent to all voluntary and community sector organisations known to the HSCB at that time, outlining the purpose and role of NIASP and the Local Adult Safeguarding Partnerships (LASPs) and inviting interested parties to self-nominate for either NIASP or a LASP. This ensured that as many interested organisations outside the core group as possible were able to engage with either NIASP or a LASP.

210. NIASP acknowledges *a complex web of governance, accountability and contractual relationships which can impact negatively on the delivery of support to adults at risk where it is thought that additional intervention is required. HSC Trusts hold ultimate responsibility for the safety and welfare of the service user and, on occasion, this has resulted in the HSC Trust assuming responsibility for interventions that would, in many situations, be better delivered by the provider organisation… Analysis of Serious Adverse Incidents in relation to adult protection and the inclusion of adult safeguarding in the core agenda for Delegated Statutory Functions also provide positive opportunities for working alongside not only adult safeguarding teams within the HSC Trusts, but also the broader systems that operate to support adults within HSC Trust structures and processes. The related shortcoming in this process, however, is that issues can become very formal very quickly and the opportunity to "move fast and fix things" can be lost.*

211. The analysis finds conflicting remits between the primary duty of a care home provider to keep residents safe from harm and neglect and the procedural interventions of the multi-agency safeguarding partners. Adult safeguarding is complex, not tailored to care homes as communal settings, demoralising for staff and confusing for residents and their relatives. At worst, adult safeguarding turns a complainant into a victim and a competent home manager into a bewildered bystander. Its potential strength is that it coordinates multi-agency action

[85] Correspondence from NIASP dated 1 August 2019.

and support to effect timely change and give residents, relatives and staff confidence that their rights will be protected and the likelihood of harm and neglect reduced.

212. The evidence points to weak links between the leadership of NIASP members and executive operations in responding to failing care homes, such as DMCH. This may be a result of the diminishing profile, authority and influence of the HSCB since 2016.

Quality Assurance

213. Safeguarding processes are founded on the distinction between the person who has been harmed and the person who is responsible for the harm. If "the system" is identified as the the perpetrator, accountability is dispersed and distorted. Whilst it is the care provider (or its staff) that is alleged to have perpetrated harm and neglect, it is in the interests of the purchaser of the sub-standard service to distribute responsibility for this around the system through the safeguarding processes. The use of consumer and contract legislation by commissioners would provide an apposite response to harmful service provision. However, this would necessitate intelligent commissioning, active care management and contract management.[86]

214. Typically, the terms of reference of commissioned reviews in England may be clustered under four headings, commissioning, care management, the provider and quality assurance.[87] As in Northern Ireland, although the adult safeguarding system is a single aspect of quality assurance, there is no evidence of its principles and practices permeating the "whole system." Other quality assurance activities are those of the provider, the Care Manager and/or contract monitor on behalf of the commissioner and service user and of the RQIA on behalf of the public. The figure below has been used during the Review's adult safeguarding workshops. Using a care home as an example, it separates the remit of care management and commissioning from service provision and from quality assurance and regulation.

215. It is significant that adult safeguarding does not feature in this figure. Adult safeguarding is most commonly invoked when the assess, plan, do and check cycle has broken down for an individual resident or for all residents. Since tiers of quality assurance processes have been unequal to warning, predicting and preventing harmful practices, adult safeguarding processes cannot feasibly remedy the failings of commissioners, Care Managers or a home's workforce. Crucially, it has no legal powers.

[86] For a study in blurred accountability, see Flynn, M. (2015) *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine* Welsh Government

[87] The terms of reference for the Whole Systems Review of Safeguarding and Care at DMCH have these in its scope.

216. The onus is on the care home provider to demonstrate that its service is effective, compassionate, safe and well-led. The Review identified a need to raise the profile of the key players – the Registered Manager, the Responsible Individual and Adult Safeguarding Champions – in this undertaking.

Commissioning and Care Management

217. In its consideration of adult safeguarding the Review Team learned about commissioning and contracting processes, care management, including admissions practice, complaints, reporting and recording and the approaches of providers to communal living. The Review Team came to the view that if each of these were performed to the required standard the need for safeguarding interventions in care homes would be obviated. Safeguarding in care homes is an activity caused by "failure demand."[88]

Data and Information

218. The Review Team sought to secure and reconcile sources of safeguarding data to either challenge or reinforce what was revealed in interviews and workshops or observed in practice. It concluded that the existing information and data culture in adult safeguarding is not subordinated to identifying the most effective use of resources. Too much is at stake for this under-developed "hit or miss" approach to gathering safeguarding data to continue.

219. The Review has revealed the need for improved information communication across the system. Partners do not understand each other's remit, duties, powers and resources - which

[88] "Failure demand" is a systems concept articulated by Professor John Seddon as demand caused by a failure to do something or do something right for the customer. See https://vanguard-method.net/2018/02/failure-demand-whats-the-big-secret/ (accessed 29 December 2019)

are not reflected in lists of "roles and responsibilities." It is not surprising that service users, their families and the general public struggled to comprehend which organisation does what.

220. Information should use precise language whether it is addressed to professionals or the public. For example, a complaint is a statement that something is unacceptable and it merits the attention of the service which gave rise to the complaint; no organisation's remit states that the permission of families should be sought before action is taken; the PSNI has the powers to investigate potential criminal activities; and the HSENI has the powers to undertake inspection and investigation activities. HSCTs have neither investigatory powers nor powers of entry.

Proposed Actions

221. The following actions are addressed to leaders at all levels to support: a strong commitment to people's human rights and freedoms; the use of readily understandable language; the development of all training within a human rights-based framework; modelling behaviour which is true to human rights and doing so in ways that sustain people's dignity and respects their humanity. The actions prepare the ground for an Adult Safeguarding/Protection Bill, strengthen governance and demonstrate a pragmatic and data dependent approach to the leadership, management and practice of safeguarding in care homes. They should be prefaced by (i) a *Statement of Commitment* from DH to facilitating change in adult safeguarding practice and (ii) laying out the requirements of an Adult Safeguarding/ Adult Protection Change Programme.

a) Establish an Adult Safeguarding/Adult Protection Change Programme

The DH should commit to effective governance by setting up an Adult Safeguarding/Adult Protection Change Programme to enact the requirements deemed essential from *Home Truths* as well as the Review's proposals. In addition to a representative group of older people and families, the Change Programme will require the involvement of care home providers and their Registered Managers, the HSCTs, RQIA and PSNI to achieve a more accountable, regional approach and more active oversight and governance. A formal and accessible structure should bridge the gaps between: (i) a Human Rights Based Framework and the operational realities; (ii) a regional approach and the different approaches of the HSCTs; and (iii) those who use care home services and those who provide them.

The work for the Change Programme over the next year includes:

- Drafting an Adult Safeguarding/Protection Bill and consulting on this
- Setting out and consulting on the contents of statutory guidance – clarity is sought on thresholds, decision-making, timely support and intervention and use of joint protocols/memoranda of understanding for example
- Developing adult safeguarding training and leadership plans
- Introducing accessible and regionally consistent safeguarding documentation.

Ultimately Adult Safeguarding/Adult Protection in Northern Ireland requires an understandable, formal structure and an arms-length arrangement with the DH. The DH

should appoint an Independent Chair and members of a Northern Ireland Independent Safeguarding Board (Adults) to advise the Permanent Secretary and Ministers on the safeguarding and protection of adults. The Northern Ireland Independent Safeguarding Board (Adults) should work alongside local groups and partnerships to secure improvements. Appointments to the NIISB (Adults) should be time limited.

b) Assert adult safeguarding/adult protection principles

The purpose of adult safeguarding and the occasions when it is invoked should be explicit and known to care home residents and their families. Actions arising from clear safeguarding principles should be proportionate and shaped by the following criteria:

- effectiveness – what evidence do we have that it works?
- balance – what account is taken of the different interests?
- the least intrusive interference possible - do professionals' actions deprive the person of the very essence of their right? [89]

Principles require the strong and sustained support of people, care homes and organisations at all levels. They should inform the basic values which provide the impetus and set the direction for all professional activities.

c) Set out a Human Rights Based Framework

The Department of Health should set out a Human Rights-Based Framework which confirms that human rights have a direct bearing on care and support.[90] The basic rights and freedoms to which every person is entitled must be given expression in preparing any new care and support provision or adult safeguarding/adult protection legislation, regulations, policies, consistent with professionals' Codes of Conduct and the common law. The Framework should promote risk-benefit assessments with the involvement of individuals, their families and/or their advocates. It should guide professionals' practice in adult safeguarding and in respect of the Mental Capacity Act (NI) 2016.

A 'Framework' carries the expectation that all care home providers have an approach to care and support that reflects the significance of human rights, the primacy of home and the maintenance of family relationships. A clear statement of purpose at the point of care home registration will facilitate the Framework's integration in practice and should be checked through inspection.

The RQIA is required to approve a Statement of Purpose at the point of a care home's registration, ensuring that a home's policies, Regulation 29 reports,[91] training programmes and practice of adult safeguarding and complaints' investigations are compatible with the

[89] Fordham, M. and de la Mare, T. (2001) Identifying the principles of proportionality. In J. Jowell and J. Cooper (Eds.) *Understanding Human Rights Principles,* Oxford: Hart Publishing

[90] Age UK sets out relevant human rights at: https://www.ageuk.org.uk/information-advice/work-learning/discrimination-rights/human-rights/ (accessed 8 November 2019)

[91] These concern visits by a registered provider or designated person to a nursing home or residential care home. See Nursing Homes Regulations (NI) 2005 and Residential Care Homes Regulations (NI) 2005

European Convention on Human Rights. This will require consultation with care home providers to establish how this is plainly reflected in practice and day to day care.

In addition, the HSCTs should explore (i) how change programmes demonstrate approaches to care and support which reflect human rights. Engagement with NISCC, the Northern Ireland Practice and Education Council for Nursing and Midwifery ("NIPEC"), the Royal College of Nursing and projects such as *My Home Life* at the University of Ulster would enhance this work; and (ii) the introduction of a regional model of training underpinned by the Human Rights-Based Framework. NIPEC's work concerning safeguarding, record keeping and competencies could be disseminated and built on.

The approach to care and support could be presented in a publication entitled "Human Rights and Living in a Care Home." As part of a "tenure agreement"[92] this would show how values such as respect, right of choice and dignity fulfil the human rights responsibility. The publication would be provided to individuals and families in advance of people taking up occupancy in care homes.

d) Draft and consult on an Adult Safeguarding/Protection Bill

A key task for the Adult Safeguarding/Adult Protection Change Programme is to set out the content of an Adult Safeguarding/Protection Bill – which should take account of COPNI's *Home Truths'* recommendations and those of his predecessor. A comprehensive consultation could, for example, agree and endorse safeguarding principles, such as giving people at the heart of service provision an equal say in the support they receive; define an "adult at risk of harm;" create duties to (i) report adults at risk of harm (ii) to make enquiries and (iii) replace the NIASP with a Northern Ireland Independent Safeguarding Board (Adults) with clearly defined duties, such as making an annual report[93] to the Permanent Secretary and Ministers. The Northern Ireland Independent Safeguarding Board (Adults) should publish annual plans and reports to inform the HSC system's annual reporting cycle. An annual accountability conference which included families would be a welcome development. By consulting on the key provisions of an Adult Safeguarding/Protection Bill, Northern Ireland will be well placed to work out and guide the interventions of all relevant authorities to provide support and avert older people's neglect or harm.

The Adult Safeguarding/Adult Protection Change Programme should draw together what is known about adult safeguarding training in NI to develop a regional model that is relevant to care homes. Training should include promoting the rights of individual residents and making safeguarding enquiries. Every opportunity for web-based education tools should be explored with a view to these being supplemented with interactive raining events and supervision. Access to online HSC Clinical Education Centre resources should be extended to the independent sector.

[92] The Regional Contract makes provision for a 'residency agreement'

[93] For example, reporting on trends and topics and identifying best practice and areas for improvement or for greater scrutiny in the coming year

e) Identify and publicise what organisations have the legal powers to do

The Adult Safeguarding/Adult Protection Change Programme should oversee the scope of adult safeguarding activities. It should identify lead responsibilities until they are established in law. This points to the need to draft an information leaflet (which may be uploaded onto relevant websites) which sets out:

- the remit, legal powers and resources of agencies
- the implications for professionals and managers
- the implications for care home owners as service providers and employers
- the implications for joint working between agencies.

Implementing the Change Programme prior to legislation will inform the development of an Adult Safeguarding/Protection Safeguarding Bill; and ensure that there is a credible, regional reporting system in the event of harm or neglect. It is too important to be left to the discretion of individual HSCTs.

f) Practice collective and pragmatic leadership

Leadership creates the environment for change. Leadership should articulate why change is necessary. It focuses and motivates managers and professionals, a team or organisation to achieve its aims. It is becoming a safeguarding mantra that it is "everyone's responsibility." It is leadership which can give the refrain meaning by, for example, asserting that all practitioners should be responsive to families reporting indifferent and harmful care home practices and take action when adults are at risk of abuse or neglect.

The *HSC Collective Leadership* Strategy[94] should support the Adult Safeguarding/Adult Protection Change Programme since it requires leaders at all levels to take a fresh look at their practices and the ways in which these benefit people. It should emphasise the context of group living and the nature of care home cultures. As well as promoting values and personalised practice it must empower the multi-professional team to make the most of their knowledge, skills and experience to prevent harm and protect care home residents. Adult safeguarding, in any setting, should not be reduced to procedures and it should not be assumed that safeguarding practice concerning children and young people is directly transferable to adults.

When commissioning a service from a care home, the HSCT should be assured that it is fully compliant with all the RQIA regulations and standards.[95] Additionally, it is responsible for ensuring that the home can meet the needs of an older person. The Registered Manager is expected to carry out a pre-admission assessment and is expected to provide a detailed care plan based on the assessed needs, wishes and choices of the individual person. The RQIA has a duty to regulate the whole service. Care homes are responsible for supplying what is

[94] Department of Health (2017) *HSC Collective Leadership Strategy: Health and Wellbeing 2026 Delivering Together* Belfast: DH

[95] See for example, the Republic of Ireland's Health Information and Quality Authority and Mental Health Commission (2019) *National Standards and Adult Safeguarding* Dublin: HIQA and MHC

specified in contracts and in residents' care plans within the law and regulations under which they are governed.[96]

Those charged with the leadership of adult safeguarding should be clear that it is not a system to remedy the shortcomings of strategic planning, commissioning, care management, inspection or policing of care homes. Adult safeguarding must be purposeful and understood and its benefits to residents known and acknowledged.

Leaders across care homes – the Registered Managers and Responsible Individuals[97] - should promote the principles and values of people's human rights and freedoms. Their networks should anticipate being supported by the NISCC, Royal College of Nursing, NIPEC, RQIA and commissioners in this endeavour.

Questions for collective leadership include:

- Are the remits of Adult Safeguarding Champions and Designated Adult Protection Officers still relevant? Or, in what way can these professionals be empowered and trusted to fulfill their responsibilities?
- What steps should Care Managers take to ensure that residents have relevant care plans?
- Does professional decision-making concerning basic fact-finding, information-gathering, and report writing require attention?
- How might examples of care homes creating value be shared?

g) Introduce action learning, research and training renewal

To create momentum, and with the endorsement of the DH, the Change Programme should engage facilitators to establish Action Learning Sets[98] with leaders from clusters of care homes, Adult Safeguarding Champions and their linked Care Managers. Since Care Managers from four HSCTs placed people at DMCH, geography need not be the determinant. Action Learning Sets will allow certain types of situations and issues, such as resident-to-resident aggression, to be explored and probed with a view to taking purposeful action as opposed to "referrals, protection planning, contract compliance [and] quality monitoring." The challenge for leaders is in permitting this to take place, learning from 'what works' and assessing the impact of outcomes. The benefits will be derived from the empowerment of key people in the system.

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[96] Flynn, M. and Citarella, V. (2020) Connecting people's lives with strategic planning, commissioning and market shaping. In S. Braye and M. Preston-Shoot (Eds) *The Care Act 2014: Wellbeing in Practice* London: Sage Publications, Learning Matters

[97] The Registered Provider must appoint a Responsible Individual *who is a director, manager, secretary or other officer of an organisation and is responsible for supervising the management of an establishment or agency* – RQIA Guidance Notes. In so doing the owner, company or charity remain accountable for the care home. https://www.rqia.org.uk/RQIA/files/fa/faf9a8ca-b8fa-415d-b52f-69079d56a387.pdf (accessed 5 August 2019)

[98] Action Learning Sets are a structured method of enabling groups to work collectively to problem-solve, innovate and develop practice

The appointed facilitator/research partner should work with identified Registered Managers, Adult Safeguarding Champions and Care Managers to prepare an account of the experience, setting out what worked, how residents and families were involved and what merits testing more widely. These contributions should be presented to the Change Programme as well as resident and family forums.

The objective is to create a contextual framework for safeguarding practice in care homes that is based on data and knowledge sharing which includes perspectives from residents and families. It would do this by understanding and problem-solving harm prevention and safety that arise in care homes. Pertinent questions are:

- How might adult safeguarding data contribute to improvements in outcomes for residents?
- Can safeguarding referrals be avoided through better ways of responding to and resolving complaints?
- How might basic fact-finding and decision-making by care home managers and/or Adult Safeguarding Champions be improved? How might the communications between Care Managers and care homes be improved?
- How might risk assessment and risk management in care homes be supported and improved?
- How can the reputation of care homes be improved? How might the care home sector engage with the media?

The merits of Action Learning Sets include:

- making knowledge, skills and experience available to participants;
- taking stock of the occasions that professionals have visited their homes for the purposes of adult safeguarding, contract monitoring and/or to address complaints;
- building networks to support better ways of working, learning from each other and understanding approaches such as risk assessment and benefits;
- improving the relationships with residents and their families and confirming their role in caring and supporting the resident that maintains the family relationships and bonds; and
- setting out ideas for alternative approaches to scenarios of harm and neglect whilst maintaining a commitment to ensuring that all statutory requirements are met.

The proposal is borne of the evidence gathered by the Review which indicates that the safeguarding system is not suited to communal living. It is too procedural, it does not solve problems, it fails to involve residents and their families and it does not prevent harm or protect people. Outcomes are expected to be practical solutions to scenarios that arise in care homes and premised on “what works.”

Independent facilitators/researchers should be commissioned, by the Adult Safeguarding/Adult Protection Change Programme, to recommend common goals, keep track of the learning process and record the ideas with the best chance of making a positive

difference – bearing in mind that learning involves creativity, risk-taking, trying something new and taking actions which might not work. The intention is to move away from safeguarding as sets of procedurally driven tasks to a learning and knowledge sharing model.

Safeguarding practice can be innovative and successful when it is based on effective risk assessments suited to the individual, combined with clarity of purpose and a vision of a good life in a care home. Senior staff in homes must be empowered as Adult Safeguarding Champions to have an active part in decision-making. The initiative proposed will be the start of safeguarding practice in care homes learning how to embed effective and practical ideas and stem the spiraling demands which arise from failures.

Training concerning adult safeguarding/adult protection in a human rights context requires renewal if it is to recover relevance. Its emphasis on generic forms of abuse and navigating the policy and procedures has not enabled professionals to re-examine and refine the challenges of risk assessments for example. The key underpinnings of the Human Rights Act 1998, the legislative architecture of Northern Ireland, the remit and powers of professionals, should orient the training and their implications for safeguarding/protection in care homes and other settings. The use of real case-studies such as DMCH and Cherry Tree House should provide situational insights, attention to different perspectives and nurture enthusiasm for interactive learning.

h) Detect what matters and use data and information to make a difference

Drawing on RQIA's work concerning "signal detection,"[99] a complementary feature may be developed for use by Responsible Individuals, commissioners, prospective residents and their families. The idea is that signals developed within homes are routinely tested and shared by the care home's Registered Manager with the possibility of providing a valuable supplement to information, inspection and Regulation 29 reports. The Adult Social Care Reform Programme could provide direction and energy to how signals can be identified involving residents, families and staff.

The Review Team notes that DH and RQIA have started more proactive engagement with care home managers and providers with encouraging attendance at the timetabled sessions. This should provide a foundation for a more formal DH-led programme of work with residential homes, nursing homes, older people, people with experience of visiting relatives in care homes and the RQIA. It should use the information gained to identify a small number of "well-being signals."[100] Since too much information gathering is duplicated and unevenly dispersed, it makes sense to identify "signals" of how well a home is functioning. It is possible to elaborate on what these may be with examples of proxy activities and approaches. However,

[99] The "risk-adjusted dynamic and responsive" (RADaR) model is designed to detect meaningful signals of risk from patterns of data.

[100] Similar to healthcare's "vital signs" of body temperature, pulse, blood pressure and respiratory rate which are important indicators of the body's essential functioning; COPNI's 'red flags' and 'warning signs' are cited in *Home Truths*. The Review Team proposes a model which seeks data about a home's strengths.

the task is one that should be undertaken with residents, families and staff. To do otherwise would risk creating another process and lose the simplicity of focusing on what matters.

The task is not to generate hundreds of signals, rather ones which highlight residents' and families' experiences of care homes that may be easily documented and shared by a Registered Manager. The importance of this is not to reinforce or duplicate performance management data and information – systems that many homes have already - but rather to sharpen the focus on what matters to care home residents.

Although comparisons of adult safeguarding referral data with previous years cannot be made without validation checking, it may be helpful to consider adult safeguarding data to date as experimental. The question is: how data and information might be useful to residential and nursing homes in terms of (i) relevance, (ii) accuracy and reliability (iii) timeliness (iv) accessibility and clarity and (v) coherence and comparability.

Subsequent Evidence Papers will similarly reflect on "what matters" and on "what works." Residents' human rights should be reflected in the sum of their care home experience – not just in adult safeguarding practice. Using data and information to promote and check self-actualization, esteem, love and belonging is less straightforward than data which reveals changes in a person's health status, for example.[101] The Review Team's proposed action is based on knowledge about the importance of the six senses[102] – security, belonging, continuity, purpose, achievement and significance - to people's well-being. Here we are making a proposal about safety and security, the second step in Maslow's hierarchy and the first of the senses, to develop an equivalent to the "vital signs" of bodily functioning.

Conclusions

222. Implementing this Evidence Paper's proposals and the recommendations of *Home Truths* (R1-R7) will be important in managing and mitigating the high risks of harm, which prevailed at DMCH, from becoming neglectful and abusive.
223. Adult safeguarding in Northern Ireland has diminishing persuasive power because its practice has strayed too far from the policy intentions of 2015 and from residents' human rights. It is to the credit of leaders in NI that some of the proposed actions are underway and it is primarily to the credit of families that they elevated their unheeded complaints to orchestrate necessary change.
224. The main findings documented in the Evidence Paper are:
    - Families' voices were repeatedly unheard at DMCH and the home did not improve.
    - Adult safeguarding practice did not actively contribute to the task of keeping DMCH residents safe.

[101] Maslow, A. (1943). A Theory of Human Motivation. *Psychological Review*, 50(4), pp.370-396

[102] *The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice* (GRiP) Report No 2. Nolan, M. R., Brown, J., Davies, S., Nolan, J. and Keady, J. Available from Sheffield Hallam University Research Archive (SHURA) at: http://shura.shu.ac.uk/280/; (accessed 4th September 2019)
Nolan, M. Lundh, U., Grant, G. and Keady, J. (Eds.) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press/ McGraw-Hill Education, 2003

- The HSCTs' practices concerning adult safeguarding would suggest that they have developed independently and without exposure to critical questioning or impact assessments – even though they have been working through similar problems.
- The boundaries of adult safeguarding have expanded to embrace care home surveillance, monitoring and inspection without legal powers or evidence of efficacy. 'Monitoring', as an activity, appears excessive, unplanned and lacking in purpose and outcome. Arguably this expanded work programme has fed a false assumption that all care homes are 'risky' and 'abusive' environments.[103]
- The public's perception of care homes is shaped by the media and most particularly via the reporting of scandals. There is no vehicle for care homes to demonstrate how they are successfully reflecting residents' support and care needs and interests. The provision of valued care in care homes is of public interest and providers must be accountable.
- Although residents' relatives knew a great deal about inattention to people's care and support, this did not impact on adult safeguarding practice or RQIA inspections. There was an asymmetry of information – the HSCTs were gathering a lot of data in their own, pre-defined terms which was not in formats which could be easily shared or understood.
- Data concerning adult safeguarding requires attention because it is unreliable, not easily retrieved and it is unequal to informing learning about types of harm and ways of preventing harm.
- An approach to risk management is required that distinguishes mistakes, accidents and questionable care practice from negligence, abuse and suspected crimes.
- All incidents and subsequent referrals require risk assessments that consider the benefits as well as potential harms of exposing people to risks.
- Professionals do not want to be party to increasing procedural baggage, sporadic actions and onerous form-filling. Their training should have a clear focus on how they gain an insight into what positively and adversely influences "the care, health, welfare or safety" of care home residents. It is in everyone's interests that they understand and promote the former and it is their duty to prevent the latter and to report harm and neglect.
- Care home providers have little influence in safeguarding practice or its follow up and yet they are expected to conform to procedures, processes and practices with few meaningful outcomes. This approach is having a detrimental impact on individuals and the collective workforce in care homes. Providers and managers describe how they are left 'in limbo' for many months before many referrals are closed quickly without a credible rationale.

[103] Data from England reveals that people are at greater risk in their own homes than in care homes. See https://files.digital.nhs.uk/33/EF2EBD/Safeguarding%20Adults%20Collection%202017-18%20Report%20Final.pdf (accessed 12 November 2019)

- Complaints to the COPNI were ultimately more effective than either adult safeguarding or RQIA inspections. Improving complaints procedures and access to them is the main priority for change. Systems tend to favour the articulate and assertive and not necessarily people with more serious complaints. At DMCH neither the articulate and assertive, nor those with the most serious complaints were listened to.

225. The starting point for an Adult Safeguarding/Adult Protection Change Programme is the question: if the DH had a 'clean sheet of paper' what would an adult safeguarding service for care homes look like? The Review's proposals begin to answer this question.

Appendix A: Sources of Data and Information

a) meetings[104] with:
   - 103 family members of residents in care homes, 86 of whom were DMCH resident's relatives, including two who wished to remain anonymous. There were 17 family members related to residents in other care homes, including one from another Runwood home and four who wished to remain anonymous. In all but two cases, they told of elderly relatives being harmed and/or neglected. Six of the DMCH families loaned documents, including video recordings, photographs and contemporaneous records of failings in care.
   - 406 care home managers and providers;
   - Four voluntary sector agencies and charities; Age NI, Alzheimer's Society, Association for Real Change, Action on Elder Abuse;
   - Eight PSNI personnel;
   - Policy advisors, MLAs and local councillors;
   - NIASP professionals with lead responsibility for drafting the adult safeguarding policy and operational procedures;
   - 176 individuals with responsibility across the five HSCTs for operationalising the policies and procedures.

b) Scrutiny of 12 filing cabinet drawers of documents submitted to COPNI from HSCTs and the RQIA; an analysis of the 100 plus safeguarding referrals concerning DMCH;

c) Safeguarding fact-finding across the HSC system through: a workshop and meetings with c.100 Belfast HSCT professionals concerning adult safeguarding practice (on 18-19 February 2019), a workshop focusing on Adult Safeguarding for over 40 practitioners from across the HSCTs on 12 March 2019; a workshop with the RQIA on 12 June 2019; an Adult Safeguarding workshop for the Directors and senior managers of HSCTs on 11 July 2019; meeting with the Northern Ireland Ambulance Service on 30 August 2019; and a meeting of hospital social workers on 19 September 2019.

d) Two working sessions attended by 78 people from across NI – Care home owners, providers and staff on 15 and 20 May 2019.

e) A meeting held on 25 May 2019, by the Transformation Team at the PHA, with 91 attendees.

f) Managers networks' meetings convened by the RCN and NISCC.

g) A meeting of the Adult Safeguarding Champions convened by ARC.

h) Correspondence and meetings with the senior managers at the Health and Social Care Board (HSCB) with responsibility for the Northern Ireland Adult Safeguarding Partnership (NIASP).

i) Meetings with the Northern Ireland Ambulance Service.

[104] In respect of family members this includes individual and group meetings, informal discussion meetings when visiting DMCH, the families' meeting called by DH, as well as telephone and email contacts. Contact ranged from multiple with some family members to a single instance with others

Contributions were sought from

a) Runwood which provided policies and procedures as well as documentation of its current approach to care practice.
b) GPs providing treatment to the residents of care home settings.
c) The HSCTs' commissioners of domiciliary care arrangements.
d) The clinicians and professionals, including social workers and nurses associated with discharging older people from hospital directly to care homes.
e) The Presiding Coroner for NI.
f) The PSNI.
g) Trade Unions, The RCN and Unison.
h) Professional Associations, the BMA, NIPEC and the RCGP.
i) Health and Social Care Regulators, NMC and NISCC.
j) Nurse consultants and academics.
k) Professor Assumpta Ryan and Sarah Penney, University of Ulster.
l) Gary Mitchell, Queens University and Kathy Fodey, as part of the Transformation Team.
m) Other Government Agencies and public bodies such as the Health and Safety Executive for Northern Ireland and the Regulation and Quality Improvement Authority.
n) The Independent Health Care Providers as the main trade association.

Appendix B: The Legislative Architecture

The legislative architecture in Adult Safeguarding is complex because reliance is placed on a range of legislative provisions that are not centred on safeguarding. The impact of the Northern Ireland legislature not being operational at the time of writing means that more creative approaches are required to enable change and reform. The following list of legislation is not meant to be prescriptive, but illustrative of the range of legal powers that may be deployed in adult safeguarding. There is a clear need for codification, consolidation and a planned system of legislative timetabling. The uncertainty of timing and the phased implementation of legislation such as the Mental Capacity (Northern Ireland) Act 2016, has led to some confusion and stress in the system. It is understood that the shortcomings of the current arrangements are acknowledged and it is accepted that change is required prior to the enactment of legislation. The overriding need for it to be enacted in the public interest has been the subject of much debate and appears to have cross-party support. There is therefore a unique opportunity to lay legislative foundations and to enable change to happen.

- Criminal Law (Northern Ireland) Act 1967
- Mental Health (Northern Ireland) Order 1986
- The Police and Criminal Evidence (Northern Ireland) Order 1989
- The Public Interest Disclosure (Northern Ireland) Order 1998
- The Criminal Evidence (Northern Ireland) Order 1999
- Family Homes and Domestic Violence (Northern Ireland) Order 1998
- Health and Personal Social Services Act (Northern Ireland) 2001
- The Health and Personal Social Services (NI) Order 2003
- Safeguarding Vulnerable Groups (Northern Ireland) Order 2007
- Sexual Offences (Northern Ireland) Order 2008
- Health and Social Care (Reform) Act (Northern Ireland) 2009
- Mental Capacity (Northern Ireland) Act 2016

Appendix C: Learning from Research

A number of comments and suggestions were made…

- *Developing clear and particular pathways for referrals arising in residential/nursing homes…which acknowledged the issues peculiar to each*
- *Introducing a fact-finding or screening stage, which was transparent, aimed at ensuring referrals were well founded and appropriate*
- *Clarifying and, where necessary, specifying the purposes of the strategy planning meeting, the circumstances under which case conferences were convened and the functions of such a meeting*
- *Introducing support for service users, alleged perpetrators and those staff involved at any stage in the adult protection process*
- *Underlining the importance of protection planning including risk assessment throughout the process* (p45).

This quotation is from a research paper published in 2000 about practice and procedures in adult protection in the Southern Health Board.[105] It sought to renew the foundations for an improved service response and proposed the introduction of a board-wide recording system enabling: activity to be enumerated; consistency with regard to activating the process; procedural dovetailing to avoid duplication; on-going education; and greater ownership among professionals and agencies since the integration of health and social care had not resulted in multidisciplinary ownership of adult protection (social workers were expected to assume the lead role). Good evidence that adult safeguarding is a long-standing and pressing matter in Northern Ireland.

The abuse of older people in residential/institutional settings is an enduring fact.[106] It has many manifestations including inattention to people's physical care; organisational factors leading to poor standards of care; fraud; the use of restraint; mistreatment by peers; and sexual assaults which tend to be under-reported and under-investigated. Research concerning the risk factors for the abuse of older people identify: the emotional and mental health problems of the person(s) responsible for harming others; a previous history of harming others; and the dependency needs of the people who are harmed – which exceed the capacity of caregivers. It is acknowledged that it is difficult to determine whether the causes of abuse hinge on the individual failings of caregivers or managerial weaknesses. Certainly, absent or deficient education concerning the care of older people; work-related

[105] Douglas, H. and Halliday, B. (2000) Reviewing practice and procedures in adult protection in the Southern Health Board *Journal of Adult Protection* 2: 2, 41-49

[106] For example, Clough, R. (1999) The abuse of older people in institutional settings: the role of management and regulation. In N. Stanley, J. Manthorpe and B. Penhale (Eds) *Institutional abuse: perspectives across the life course* London: Routledge

stress/burnout; a poor working environment/inadequate resources to provide good care; and the expectations imposed on a low paid workforce of mostly women play their part.[107]

With reference to sexual assaults in residential homes, research confirms that its discovery brings forth hitherto unexpressed views and attitudes concerning the sexuality of older people which impact on how allegations are addressed. For example, views concerning the appropriateness of an assumed relationship may be "resolved" by separation to different parts of a home and reference to mental capacity. A source of keen frustration for homes' managers and staff is discussion concerning allegations of sexual assault and adult protection investigations which are "unproven."[108]

A key structural cause of the neglect of older people in nursing homes is *the law's emphasis on physical disability and frailty and its underestimation of time needed to care for people suffering with dementia* (p15).[109] A consideration of the findings arising from 251 qualitative interviews in eight nursing homes, a survey among 22 nursing home staff and an analysis of cases known to law enforcement and "nursing home control agencies" in a single German state reported paternalism, infantilisation, psychosocial neglect and verbal aggression more frequently than physical assaults, neglectful care or the inappropriate use of restraints, for example. While incidents of physical violence against residents were generally of low to moderate severity, the picture changed *if reports from observers were included…night shifts are characterised by especially low staffing which may imply extreme work stress and a low chance of detection and prosecution of misbehavior…nurses behaviour seemed to be triggered by residents' faecal incontinence* (p18). In contrast to physical violence, specific incidents of neglect were perceived as something for which individual nurses were not responsible. The survey revealed that almost ¾ of 361 staff reported that they had witnessed a at least one harmful incident performed by a colleague in the preceding 12 months. They estimated that four out of five incidents of abuse and neglect were not reported to managers. Analysis pointed to the role of qualified nurses in reducing "residents' risk of victimisation" (p21). In almost 40% of inspections, evidence of abuse or neglect was identified. Analysis of 35 public prosecutor files revealed two types of cases relating to (i) neglect and insufficient medical treatment in nursing homes and (ii) cases of physical maltreatment, including sexual assaults by nursing staff, managers and owners. The strengths and limitations of the respective approaches demonstrate that the combination of qualitative and quantitative information and *a multitude of perspectives and data on detected and undetected cases produce a more comprehensive picture of abuse and neglect in institutions of long-term care* (p25).

There is a comparative dearth of primary research on elder abuse in the UK which, compounded with difficulties in reporting cases, has led to difficulty in reporting figures

[107] Parker, J. (2001) Seeking effective approaches to elder abuse in institutional settings *Journal of Adult Protection* 3:3, 21-29

[108] Jeary, K. (2004) Sexual abuse of elderly people: would we rather not know the details? *Journal of Adult Protection* 6:2, 21-30

[109] Goergen, T. (2004) A multi-method study on elder abuse and neglect in nursing homes *Journal of Adult Protection* 6:3, 15-25

(p28).[110] This problem is exacerbated by different levels of understanding concerning abuse and the actions which should be taken. This is confirmed by a small study which sought the views of care home managers and residents[111] about how different types of harm to residents might be addressed. It revealed that managers' perceptions of the seriousness of an incident, prior experience of dealing with abuse scenarios and confidence in seeking external advice and support determined their responses. There were wide variations in the reporting of certain incidents. Similarly, residents' views differed with some expressing sympathy with the challenges of working in a residential service.

An analysis of calls to Action on Elder Abuse's helpline between 1997 and 1999 showed that almost 30% concerned abuse in care homes and hospitals.[112] Subsequent studies[113] suggest that this considerably underestimates the extent of harm in care homes. However, prevalence figures vary according to the sources of data, the methods and timeframes used.

There are elements of service cultures and environments that are associated with the potential to provide early warning or indicators that all is not well.[114] Managerial failings at all levels are associated with abusive environments. Staff attitudes and behaviours have a significant role in maintaining or infringing residents' safety – highlighting the importance of skilled and competent managers promoting the development and maintenance of staff skills, knowledge and understanding. Isolation is a key element of abusive services as staff become removed from new ideas and unable to recognise the poverty of conditions and practices. Service design, placement planning and commissioning may result in failure to deliver agreed plans; and failure to recognise the ways in which residents may express their harmful experiences or their propensity to harm others are consistent with themes arising from enquiries.

Efforts to abstract learning from adult safeguarding reviews exercises practitioners and their organisations. An overview of adult Serious Case Reviews in two English local authorities identified the importance of considering levels of outcome.[115] (The content of Table 1 has been slightly modified to reflect Northern Ireland's authorities.)

[110] Manthorpe, J. Perkins, N., Penhale, B., Pinkney, L. and Kingston, P. (2005) Select questions: considering the issues raised by a Parliamentary Select Committee Inquiry into elder abuse *Journal of Adult Protection* 7:3 19-32

[111] Furness, S. (2006) Recognising and addressing elder abuse in care homes: views from residents and managers *Journal of Adult Protection* 8:1 33-49

[112] Bennett, G. Jenkins, G. and Asif, Z. (2000) Listening is not enough: An analysis of calls to Elder Abuse Response *Journal of Adult Protection* 2:1 6-20

[113] For example, Cambridge, P. Beadle-Brown, J. Milne, A. Mansell, J. and Whelton, B. (2006) Exploring the incidence, risk factors, nature and monitoring of adult protection alerts, Canterbury: Tizard Centre

[114] Marsland, D., Oakes, P. and White, C. (2007) Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings *Journal of Adult Protection* 9:4 6-20

[115] Brown, H. (2009) The process and function of serious case review *Journal of Adult Protection* 11:1, 38-50

Table 1: Layers of outcome

Levels and contexts	Outcomes
For the person who has been harmed	Attention to immediate safety, possibly an emergency medical response; a risk assessment; a review of the care plan and risk management; longer term support for recovery; redress; appropriate reporting; clinical review.
For the person(s) associated with the harm	Criminal justice; employment, disciplinary action; barring from the workforce; fitness to practice procedures by the regulator; extra assistance, training and supervision if a service employee; other civil enforcement such as an injunction; extra assistance and enhanced care, support and communication, if a relative.
For the provider service	Review of RQIA registration requirements and a service's adherence to its registered purpose; scrutiny of its policies and procedures; scrutiny of RQIA inspection reports; use of regulatory enforcement, including closure; professional advice and consultation; communication with relevant authorities.
For the HSCTs	Changes to contracts; monitoring of contracts; re-provision of the service; interagency support; review of suitability of individual provision; liaison with person harmed and their family.
For the HSCB	Commissioning health and social care services for the population of Northern Ireland**.** Oversight of the Regional Contract and procurement of care home services with specific reference to safeguarding.
For the Health Minister	The HSCB is accountable to the Health Minister, for turning their vision for health and social care into a range of services that deliver high quality and safe outcomes for patient and service users. The Minister discharges this duty through the DH.
For the Legislative Assembly	Acknowledgement of gaps in remit, powers and duties of the HSCTs and RQIA; setting legislative direction and changes in policy.
Secretary of State	The Assembly has jurisdiction over areas that are not explicitly reserved to the Parliament of the United Kingdom. If the devolved legislature is in a period of suspension - as it was at the time of writing - its legislative powers can be exercised by the UK Government at Westminster. The Secretary of State for Northern Ireland is the Principal Secretary of State with responsibilities for Northern Ireland.

The Table underlines the importance of describing an incident and the conditions which led to it; identifying the key events and failures; and setting out the management and organisational factors that allowed it to happen. The author notes that *the misreading or failure to reach consensus about the respective contribution of individual culpability and corporate responsibility…seem to be the main challenges that test a system that was originally conceived of as a way of addressing one-off incidents caused by individuals, as opposed to the realities of ongoing, poor quality care or badly managed or resourced service provision* (p46-47). Decision-making may be compromised by the challenges of untangling *the relative contributions of different agencies and departments within those agencies, to the conditions pertaining in a poorly performing service…There are many and sometimes too many parties at the table in some instances* (p48).

Efforts to improve the quality of care of people receiving services in a Welsh Borough Council were occasioned by the "dilemma of how failing services are supported."[116] That is, should a local authority wait for a provider to demonstrate improvements while assisting the provider? Should a local authority respond to requests from providers to supply staff at care and managerial levels? This local authority's experience of using embargoes showed that *they are effective in making short-term improvements…but it is questionable as to whether they are effective in achieving sustained improvement* (p10). Additional dilemmas concern a provider's self-imposed embargo. Should the local authority accept this or layer on another embargo? Should reassurance be offered to service users that although new placements are not being commissioned, *monitoring and improvement meetings are taking place"? The local authority identified two key themes: (i) there is conflict when poor performance is associated with inadequate numbers of staff and (ii) changes of management are an "early indicator" of potential risk.* It noted that the quality of a service improves or deteriorates in response to a change of manager, *compounded by the fact that leadership, supervision and the ability to recognise and challenge poor practice may not be cascaded down through the tiers of staff below* (p11). The benefits of the provider performance monitoring included improved relationships with the majority of providers; improved understanding and communication between internal departments and external agencies; an enhanced quality monitoring profile; and strategic commitment to the early identification of potential risks.

Research evidence concerning "training transfer – the use of acquired knowledge or skills once back at work" identifies the significance of the training provider, the delegate and the delegate's organisation/manager.[117] Four factors in particular are identified as being important in influencing training transfer: individual characteristics e.g. motivation and perceived utility of attending; training design and delivery e.g. content relevance to job and follow-up; transfer climate e.g. manager and peer support and opportunity to use training;

[116] Giordano, A. and Street, D. (2009) Challenging provider performance: developing policy to improve the quality of care to protect vulnerable adults *Journal of Adult Protection* 11:2, 5-12

[117] Research in practice for adults (2012) *Training transfer: getting learning into practice* Dartington: RiPfA

and subject climate e.g. the match between what training says should happen and what happens.[118]

A Serious Case Review in England concerning a single care home, Summer Vale Care Centre for older people,[119] found that it did not ensure the safety of its residents; although the exact number of abusive incidents in the home was unknown, a dismal picture of the lives of residents emerged; a woman who was a National Health Service Continuing Healthcare funded patient was repeatedly physically and sexually assaulted; there were lots of incidents and concerns and even though there were around 60 professionals involved in making sense of this information, all of whom agreed that something should be done, no one asked searching questions and no one assumed a lead role; Summer Vale Care Centre did not train or supervise its staff; those who asked the home to provide placements and those who inspected it believed the home's managers when they said that they were "monitoring" residents who were either violent and harmed people sexually or were the victims of assaults.

The safety of healthcare workers supporting people with dementia[120] was explored via a postal survey (with a 35% response rate) in care homes in the independent sector in Northern Ireland. Of these respondents, two thirds reported that they had experienced incidents which caused them to fear for their safety. The most serious events which respondents were involved in or witnessed included being grabbed around the neck, kicked on the chest and sexually harassed, for example. The study concluded that healthcare workers frequently fear for their safety. How staff make sense of the events and reflect on the threats posed are unrelated to the injuries sustained. Most assaults take place during care interventions and care staff were wary of working alone with residents whose behaviour was aggressive. The experience of urgently seeking the assistance of colleagues was reported as distressing. While the support of peers at work was valued, formal managerial support was less forthcoming.

Little is known about the employment of agency staff to fill staffing gaps.[121] Typically agency staff are under contract with an employment agency or business and are not permanent members of staff. The employment agency is responsible for their recruitment, and the workers themselves offer and have to accept flexibility, sometimes in return for higher rewards than they might earn in permanent posts. A mixed methods study found that agency staff were most likely to be recruited when posts required filling quickly and "safeguarding issues were involved." Private sector home care and care home providers rarely sought agency care workers due to the costs and business viability. The research concluded that

[118] Pike, L., Gilbert, T., Leverton, C. Indge, R. and Ford, D. (2011) Training, knowledge and confidence in safeguarding adults: results from a postal survey of the health and social care sector in a single county *Journal of Adult Protection* 13:5, 259-274

[119] Flynn, M. (2011) Serious Care Review Executive Summary: Summer Vale Care Centre, Leicester

[120] Scott, A., Ryan, A., James, I.A. and Mitchell, E. (2011) Psychological trauma and fear for personal safety as a result of behaviours that challenge in dementia: the experience of healthcare workers *Dementia* 10:2 257-269

[121] Manthorpe, J., Cornes, M. and Moriarty, J. (2012) Considering the safeguarding risks presented by agency or temporary social care staff: researching findings and recommendations *Journal of Adult Protection* 14:3, 122-130

agency or temporary staff in care homes and community settings should be considered as part of "risk-minimisation strategies." However, they need to know about, *inter alia,* safeguarding practice since the poor management of agency workers may pose a risk rather than the fact of agency working itself. The study concludes that commissioners should consider making safeguarding training available to agency staff.

A consideration of the factors which enable the abuse and maltreatment of older people[122] opened with older people's categorisation of the abuse of older people as determined by the World Health Organisation in 2002:[123]

- Deprivation: of choices, decisions, status, finances and respect
- Violation: of human, legal and medical rights
- Neglect: isolation, abandonment and social exclusion.

The Joint Committee on Human Rights[124] inquiry into breaches of older people's human rights in the UK suggested that older people in hospital and residential care "routinely receive inhumane and degrading treatment." Structures which emphasise liberty, individual freedom, responsibility, free markets and minimal state intervention have resulted from the deregulation of economic activity. In addition, the increased privatisation of previously publicly delivered services to older people – or "consumers of care" – implies choice and an ability to buy private care. This neatly transfers responsibility from the state to the individual. Practice which might constitute abuse and maltreatment is not recognised as such and may be tolerated in an effort to meet organisational needs. Structural reform has to parallel reforms at an individual level and this must emphasise dignity over price and compassion over cost.

It is recognised that the experience of poor treatment in care homes for older people cannot be separated from broader institutional and societal issues which underpin homes and their related systems.[125] Care home residents cannot avoid contact with staff and/or other residents and there is a requirement to submit to the home's routines. Although human rights are closely aligned to adult safeguarding and there are many examples of actual or potential breaches of human rights in care homes and nursing homes, "policy priorities" have not favoured older people being supported in their communities. In contrast, the care home and nursing home sector has grown – which is arguably an anti-human rights development.[126] How may a care home give expression to the right to liberty if residents with mental capacity

[122] Galpin, D. (2012) The role of social defences and organisational structures in facilitating the abuse and maltreatment of older people *Journal of Adult Protection* 14:5, 229-236

[123] World Health Organisation (2002) *Missing Voices: Views of Older Persons on Elder Abuse* Geneva: WHO

[124] House of Lords House of Commons Joint Committee on Human Rights *The Human Rights of Older People in Healthcare.* 18th Report of Session 2006-07, Vol 1 Report and Formal Minutes. HL Paper 156-1, London: The Stationery Office

[125] Phelan, A. (2015) Protecting care home residents from mistreatment and abuse: on the need for policy *Risk Management and Healthcare Policy* 8: 215-223

[126] Quinn, G. (2013) *Age: from human deficits to human rights – reflections on a changing field.* Launch event – Human Rights and Older People Working Group, *Human Rights and Older People in Ireland*

are not allowed to leave unless they are accompanied? *In the context of care deficiencies, it is imperative that a multi systems approach requires attention not only to emergent issues but also on how such issues are interrelated to produce maltreatment, missed care, failure to rescue or never events…Policy needs to acknowledge the macrosystem within which beliefs and values of societies in relation to older people emerge and acknowledge how such perspectives (such as ageism) can have an impact on care delivery and care experience…a global debate is necessary on the need to diversify care delivery options as care homes are the most dominant and, in many countries, unilateral way of caring for older people with heightened care needs* (p219).

Although the media have a prominent role in exposing poor practice in care homes, care staff report problems in raising questions and concerns in certain workplaces.[127] It was the serendipitous broadcast of an undercover TV documentary during a study of England's social care workforce that led to consideration of its impact. Spins on the coverage involved the "CCTV industry – which was positive about the ethics of using CCTV technology;" speculation that families were given "the green light to spy" on care homes; and the dismay of consultants specialising in the care of older people that if local clinicians had been on task, some people might have been enabled to remain in their own homes. Subsequent data from interviews with 112 care home managers and 117 staff revealed that most were positive about the role of the media in exposing abuse. However, they acknowledged that cameras, per se, are not a solution to whole system issues, not least because media coverage impacts on the reputation of all care homes.

An explorative, quantitative study of Norwegian nursing homes for older people secured information from over 600 staff and home managers.[128] The most consistent finding was that "resident aggression" increased the probability of inadequate care, abuse and neglect. It appears that the probability of inadequate care of an emotional and physical type increases significantly in rural areas. However, it acknowledges the possibility that more skilled staff are drawn to urban areas.

It is widely accepted that organisational cultures are critical to promoting harm and mistreatment. A qualitative study about "early indicators of concern"[129] in residential services for older people identified six significant domains which may guide and inform. That is:

i) management and leadership
ii) staff skills, knowledge and practice
iii) residents' behaviours and well-being
iv) the service resisting the involvement of external people and isolating residents

[127] Manthorpe, J., Njoya, E., Harris, J. Norrie, C. and Moriarty, J. (2016) Media reactions to the Panorama programme "Behind Closed Doors: Social Care Exposed" and care staff reflections on publicity of poor practice in the care sector *Journal of Adult Protection* 18:5, 266-276

[128] Malmedal, W., Hammervold, R. and Saveman, B. (2014) The dark side of Norwegian nursing homes: factors influencing inadequate care *Journal of Adult Protection* 16:3, 133-151

[129] Marsland, D., Oakes, P. and White, C. (2015) Abuse in Care? A research project to identify early indicators of concern in residential and nursing homes for older people *Journal of Adult Protection* 17:2, 111-125

v) the way services are planned and delivered

vi) the quality of basic care and the environment.

This study endorses the perceptions of experienced health and social care staff who visit residential services for older people. Since they are attuned to signs that a service is deteriorating, their judgement and discretion is more effective than disputes concerning safeguarding thresholds for example.

A review of the neglect of older people in care homes in south east Wales[130] described the indifferent care home practices which harmed older people. Their relatives were unaware of the poor reputations of the GP owners, the homes' managers or of the homes where the relevant regulations were repeatedly tested and breached. Families perceived the inattention to residents' hydration, nutrition, physical comfort, hygiene, unexplained injuries and deep pressure ulcers as the abandonment of common humanity and a reflection of the unchecked greed of the businesses which owned the homes concerned. Between 1994-2006, the Health and Safety Executive had issued 12 improvement notices to the GPs' homes. The regulator was required to demonstrate that reasons for deciding to close a home remained compelling at the point of closure – which was compromised by health and social care agencies "stepping in" to shore up failing practice since this masked the failures of the registered provider. The regulations at the time required inspectors to take action on a home by home basis. There were mistakes and errors of judgement. The Crown Prosecution Service's assertion that the case would have fallen on the basis of lack of evidence should have been tested before a jury; the legal context of residential services and corporate governance require attention; better corporate safeguards are required to ensure good governance; the poor standards of care provided by the GPs' companies may have rendered them liable in contract to commissioners and proceedings could have been taken under the Company Directors Disqualification Act 1986; extensive media coverage and safeguarding investigations proved insufficient in securing a fair and legally sanctioned resolution; no single agency or profession assumed a lead role in addressing breaches of trust, neglected contractual duties or the harms endured by older people; the parameters of the police investigation were too broadly drawn; inter-organisational cooperation was overshadowed by ambiguity and suspicion as the police investigation extended; aspects of palliative care such as the management of pain and the provision of emotional comfort were remote from the experience of older people within the GPs' homes. One of the lessons from the review was, *private interest pursued at the expense of others has a long history. However, the public interest cannot be subordinate to the short-term personal gains or even the criminality of a minority of care home directors* (p231).

The repetitive familiarity of particular forms of abuse – rough handling, dangerous lifting techniques, insults and tormenting, which sometimes arise in the same care homes, prompts

[130] Flynn, M. (2015) *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine* Cardiff: Welsh Government

the question: is safeguarding a job for life?[131] The staff of five new care homes responded to an anonymous questionnaire concerning witnessed or suspected abuse. The findings indicate that the abusive realities of care homes evade detection by regulatory and monitoring activities. The research concludes that more thorough ways of assessing the suitability of potential care staff and regulation are required that look *beyond the relatively superficial artefacts of care home organisation* (p224).

The concealment of abuse in care homes[132] is attributed to intimidation, fear of eviction and reprisals, for example. Staff may fear such personal consequences as victimization, intimidation, ostracism and loss of employment. It brings into question the distance between worthy policy and the prevailing practice environment. Interviewees were dismayed by the quasi-judicial, fault-finding approach of safeguarding inquiries and regarded this as a deterrent to honestly reporting events. The research confirms the significant under-reporting of abuse and the failure of existing regimes to protect older people in residential services.

The recurring and persistent challenges to effective inspection and regulation are not new.[133] For example, beliefs about the causes and effective treatment of "lunacy" in nineteenth century Scotland shaped the design of inspection services. In 1822 there was *an average of one Commissioner for every 4,400 lunatics in Scotland* (p120). Using Scotland's Care Inspectorate's four themes employed in its grading (care and support, environment, staffing, leadership and management) to make time comparisons revealed that: nineteenth century standards hinged more on the environmental features of care and the site of asylums; and an early interest in staff "characteristics" gave way to the importance of specialist training. The importance of management to ensure the fidelity of patient care was evidenced in early inspections. Scotland's emergent inspection practice is driven by the need for a balance between evidence and value-based judgements as well as "best value" considerations. It is recognised that there is *no ideal format or comprehensive system of inspection of services as yet*. However, *a publicly available ratings approach was more likely to be successful for social care*… and difficult decisions remain about the most effective methods of regulation and inspection.

Safeguarding functions are predominantly reactive to the abuse of older people in residential services. An investigation of personal value frameworks[134] conducted in 12 care homes revealed that these are significant factors in the creation of circumstances in which abuse may occur. However, the assumption that all staff positively value older people in their care is typically untested. Unless the decision to work in a home is positive, premeditated and

[131] Moore, S. (2016) Safeguarding vulnerable older people: a job for life? *Journal of Adult Protection* 18:4, 214-228

[132] Moore, S. (2016) See no evil, hear no evil, speak no evil? Underreporting of abuse in care homes *Journal of Adult Protection* 18:6, 303-317

[133] Campbell, M. (2017) The journey from first inspection to quality standards (1857-2016): are we there yet? *Journal of Adult Protection* 19:3, 117-129

[134] Moore, S. (2017) What's in a word? The importance of the concept of "values" in the prevention of abuse of older people in care homes *Journal of Adult Protection* 19:3, 130-145

regarded as a worthwhile choice, practices will prevail which are incompatible with valuing older people.

Adult safeguarding experience in Northern Ireland *has moved towards a more person-centred approach with a drive to involve service users in shaping services* (p237).[135] Specialism dictates responses. That is within the five integrated HSCTs, there are either specialist teams managing the referrals deemed to be "high risk" with generic locality teams attending to the lower-risk referrals, or all cases are managed by generic practitioners trained to combine the tasks of investigation and adult protection. A pilot study sought to adapt a method of gathering feedback (10,000 voices) from those involved in services to adult safeguarding experiences. Out of 36 people, 35 provided a narrative account of their experiences and provided "an opportunity for debrief and closure." People's responses were largely positive and where it was offered, negative feedback focused on matters not being addressed and inconclusive outcomes.

The public communications of care homes concerning human rights are revealing in terms of corporate responsibility.[136] Based on a qualitative content analysis of the websites of 71 large commercial care home providers, a study revealed that although providers use value-based public communications, these "may or may not be interpreted to be an express commitment to human rights" (p358). Since the Human Rights Act 1998 is directly relevant to registered providers, the actions of all public authorities must be compatible with human rights under the 1998 Act. Accordingly, the English regulator adopted a human rights approach to regulation and inspection.

Are regulation, inspection and commissioning ineffective in combating abuse?[137] Regardless of the introduction of National Minimum Standards in 2002, which are grounded in good practice, the Care Quality Commission reported that 26% of care homes and 41% of nursing homes were rated as either "inadequate" or "requires improvement."[138] Therefore it appears that there is a limit to the effectiveness of the regulator's scrutiny in terms of improving the sector and preventing abuse. In addition, the contract monitoring function regarding care homes is "superficial and reactive…many of the staff employed…to manage and monitor contracts…often lack the skills and experience to do so" (p422-423). A "back to basics" approach is advised which hinges on the personal value frameworks of potential home staff and managers, scrutiny during the evenings and at weekends and the introduction of surveillance technology.

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[135] Montgomery, L., Hanlon, D. and Armstrong, C. (2017) 10,000 Voices: service users' experiences of adult safeguarding *Journal of Adult Protection* 19:5, 236-246

[136] Emmer de Albuquerque Green, C. (2017) Exploring care home providers' public commitments to human rights in light of the United Nations Guiding Principles on Business and Human Rights *Journal of Adult Protection* 19:6, 357-367

[137] Moore, S, (2017) If you always do what you have always done, you will always get what you have always got: commissioning and regulating care homes to prevent abuse *Journal of Adult Protection* 19:6, 418-430

[138] Care Quality Commission (2016) *The State of Health and Social Care in England 2015/2016* Newcastle-upon-Tyne: CQC

A Knowledge Transfer project in Northern Ireland[139] sought to improve the quality of older people's lives in nursing and residential care homes. It began in 2013, with 15 care home managers implementing practice development initiatives about: facilitating a positive transition for residents and relatives; maintaining dignity and identity; sharing decision making; and creating and maintaining community links. The project went on to facilitate the leadership skills of 49 home managers and to enhance relationships within the home and with residents' relatives. The authors proposed that such findings should *be disseminated to balance the negative public image of care homes that currently prevails* (p1).

Interviews with three former care staff "who had committed abusive acts" reveal their discomforting perceptions and values.[140] Although they had not planned to become care workers, they needed employment and there were no barriers to their appointment. There was no rigour to their interviews, there were no checks on their references, their induction was superficial, their early experience of work in care homes was poor and their movement between homes was unhindered. They each conformed with the harmful and disrespectful practices they encountered at the outset of their employment in care homes. Their need for salaried work trumped their conduct as employees. Their unchallenged perceptions of older people were that they are entirely without worth and less than human. The three ex-employees were wholly dismissive of external scrutiny which gathered nothing of prevailing care practices.

Hospital admissions from nursing homes generally hinge on GPs' decision-making.[141] Interviews with 21 GPs confirmed that their starting point was the assessment of the patient's medical condition and the risks versus benefits of hospital admission. The patient's own wishes and those of their relatives had significant roles in decisions, in addition to medico-legal matters. Access to information was similarly instrumental in determining whether an admission should proceed with GPs more likely to admit if information was missing. The capability of the home care staff and their attitudes towards palliative care were considerations. Younger GPs were perceived to admit more readily than more experienced GPs. Ideas for improving practice concerned: improving communication; increasing nursing home training; using specialist nurses; and peer support for GPs.

Since older people living in residential care homes have limited life expectancy, care homes are increasingly regarded as providers of palliative care for older for older people.[142] Six homes in three English localities were the focus of one study. During its timeframe, 23

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[139] Ryan, A. and Penny, S. (2018) *Improving quality of life in nursing and residential homes by implementing an evidence-based programme of best practice and person-centred care: My Home Life* Northern Ireland. Belfast: HSC Public Health Agency, Research and Development Division

[140] Moore, S. (2019) Paths to perdition: exploring the trajectories of care staff who have abused older people in their care *Journal of Adult Protection* 21:3, 169-189

[141] McDermott, C., Coppin, R., Little, P. and Leydon, G. (2012) Hospital Admissions from nursing homes: a qualitative study of GP decision-making *British Journal of General Practice,* August 2012, e538-e545

[142] Barclay, S., Froggatt, K., Crang, C., Mathie, E., Handley, M., Illife, S., Manthorpe, J., Gage, H. and Goodman, C. (2014) Living in uncertain times: trajectories to death in residential care homes *British Journal of General Practice,* September 2014, e576-e583

residents died out of 121. Interviews and scrutiny of case notes led to the identification of four trajectories:

i) anticipated dying – this affected the largest number of residents
ii) unexpected dying – these residents had been stable until an illness that was not obviously life threatening but which led to death within days
iii) uncertain dying – although these residents were unwell, they were not close to death but were admitted to hospital for further investigations or treatment
iv) unpredictable dying – these residents had been stable but experienced an unexpected and acute event.

Primary care services have an increasing role in the care of frail older people.[143] A study seeking to determine the long-term outcomes of older people discharged from hospital following short admissions (of under three days) took into account their frailty status. It found that people deemed to be frail, who are discharged from hospital, are at high risk of poor outcomes, that is, they experience increased mortality and resource use. Thus, there are compelling reasons to avoid even brief hospital admissions. However, since falls, delirium or sudden loss of mobility are typical "frailty crises," there is an incentive to invest in their primary prevention and in enhancing community support to those being discharged.

Taken individually, the research cited is narrow in focus and limited in its contribution to our understanding of the abuse of older people in care homes. Together however, the studies provide a wide-angled picture, including the "signs" that things are going wrong. The themes and insights are true to the complexity of the topic – which is not new to Northern Ireland. It is evidenced in all forms of residential care and institutions where people have interdependent relationships. The values and behaviour of the manager are pivotal. A change of manager is a time of risk. The most important job of that manager is the selection of care practitioners, their training, supervision and support.

There can be no guarantees of absolute safety in care homes. What is possible is the provision of timely support to residents associated with harm and to the Registered Manager since practice is necessarily highly situational. Managers must be alert to identifying the "signs" of potential problems and preventing these from becoming harmful crises.

It follows that research points to investing in Registered Manager development and succession planning; in making the Responsible Individual's position one for competent and experienced people; in making the Regulation 29 reports readily available to all visitors, most particularly residents' relatives; and seeking forms of training, inspection and governance that are attuned to the signs associated with an increased likelihood of abuse and neglect.

[143] Keeble, E., Roberts, H., Williams, C.D., van Oppen, J. and Conroy, S.P. (2019) Outcomes of hospital admissions among frail older people – a 2-year cohort study *British Journal of General Practice,* August 2019, e555-e560