Adult Safeguarding within a Human Rights Based Framework

Evidence Paper: 1, Learning and Change Briefing, September 2020

Contents

Background 2

Summary of Review Team's Main Findings 3

Proposed Actions 5

- **a) Establish an Adult Safeguarding/Adult Protection Change Programme** 5
- **b) Assert adult safeguarding/adult protection principles** 6
- **c) Set out a Human Rights Based Framework** 6
- **d) Draft and consult on an Adult Safeguarding/Protection Bill** 7
- **e) Identify and publicise what organisations have the legal powers to do** 8
- **f) Practice collective and pragmatic leadership** 8
- **g) Introduce action learning, research and training renewal** 9
- **h) Detect what matters and use data and information to make a difference** 11

Concluding Statement 12

Background

1. Families' resolute pursuit of truth has led to this Review. The work of the Commissioner for Older People for Northern Ireland ("COPNI") has played a pivotal role in finding out what happened to their relatives, older people at Dunmurry Manor Care Home[1] ("DMCH"), and politicians have asked much-needed questions when the Assembly was suspended. The power of investigative media has made a major contribution in challenging the wide discrepancy between the hopes of these families and the harms their relatives endured.
2. This Learning and Change Briefing derives from the Review Team's Evidence Paper concerning Adult Safeguarding. It sets out the pressing matters which require attention and presents an opportunity for those in positions of authority to make different and improved responses as soon as possible. This is what the families, residents and everyone working in the system deserves if trust in funded care for older people in NI is to be restored.
3. The Briefing concerns the protection of older adults with different support needs from neglect, harm and poor care in residential and nursing homes. Its purpose is to inform and advise those who are responsible for formulating and implementing change. It draws on an imperfect jigsaw of sources.[2] It expands on the COPNI's findings concerning the experience of older people at DMCH as published in *Home Truths;* it addresses the whole adult safeguarding system around care homes; and it considers the interfaces of adult safeguarding with complaints, contracts and regulation for example. The Briefing sets out the emergent lessons and proposals for change.
4. The 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 references peer-reviewed articles concerning systemic neglect in residential and nursing home settings and the ways in which its likelihood may be reduced. Its "proposed actions" arise from discussions with families and professionals across health and social care. It is brought forward in advance of the full report of the whole systems review as part of the DH's "statement of commitment" to learn and make changes, enhance the lives and safety of people known to services, mobilise the resources necessary to achieve valued outcomes and improve adult safeguarding practice.
5. There are several actions that ought to be taken and can be initiated without waiting for the perfect solution or the right time. 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, they should involve families and demonstrably add benefit to people's lives. They must be proportionate, risk-benefit based and credible.

[1] It has been renamed Oak Tree Manor by the owners Runwood Homes. For the purposes of the Independent Review, the name Dunmurry Manor Care Home (DMCH) has been retained.
[2] The sources of adult safeguarding data and information feature in Appendix A of the Evidence Paper.

Summary of Review Team's Main Findings

6. 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. The main findings documented in the Evidence Paper are:
   - Families' voices were repeatedly unheard and DMCH did not improve.
   - Adult safeguarding practice did not actively contribute to keeping DMCH residents safe.
   - 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.[3]
   - 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

[3] 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)

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.

- 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. With DMCH residents and families, neither the articulate and assertive, nor those with the most serious complaints were listened to.

7. 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.
8. 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 to have good lives in care homes whilst recognising the risks and realising the benefits of living in a care home community.
9. Much safeguarding practice is premised on the conviction that people must be kept safe at all costs. Since the approaches developed in NI are not supported by research, safeguarding is an inadequate and blunt response. There are more effective and nuanced approaches to addressing the challenges which arise from living in communal settings. It appears that safeguarding is the only tool within reach.
10. 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 adult safeguarding interventions for care homes look like? The following proposals begin to answer this question.

Proposed Actions

11. To create the environment for change the actions proposed 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. Such actions prepare the ground for an Adult Safeguarding/Protection Bill, strengthen governance and demonstrate a pragmatic and data-based approach to the leadership, management and practice of the safeguarding system in care homes.
12. This Briefing is based on eight proposals.
    a) **Establish an Adult Safeguarding/Adult Protection Change Programme**
    b) **Assert adult safeguarding/adult protection principles**
    c) **Set out a Human Rights Based Framework**
    d) **Draft and consult on an Adult Safeguarding/ Protection Bill**
    e) **Identify and publicise what organisations have the legal powers to do**
    f) **Practice collective and pragmatic leadership**
    g) **Introduce action learning, research and training renewal**
    h) **Detect what matters and use data and information to make a difference**
13. The Review Team urges DH to take immediate action to (i) make a "Statement of Commitment" to facilitating change in adult safeguarding alongside commissioning, care management, the provision and regulation of care homes and (ii) lay out the requirements of an Adult Safeguarding/Adult Protection Change Programme.
14. Implementing the proposed actions from the Evidence Paper and the *Home Truths'* recommendations concerning adult safeguarding and human rights (Recommendations 1-7) will be instrumental in creating a whole system which manages and mitigates the high risks of harm, which prevailed at DMCH, from becoming neglectful and abusive. Moreover, it will start to create a better environment in which people who live and work in care homes can flourish.

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? [4]

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.[5] 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 must have an approach to care and support that reflects the significance of human rights, the primacy of home and the

[4] 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

[5] 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)

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,[6] training programmes and practice of adult safeguarding and complaints' investigations are compatible with the 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"[7] 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[8] 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.

[6] 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

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

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

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 supervision and face to face training and development. Access to online HSC Clinical Education Centre resources should be extended to the independent sector.

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.

Implementation of 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 they must report adults at risk of abuse or neglect.

The *HSC Collective Leadership* Strategy[9] 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 neither be reduced to policy and procedure nor should it be assumed that safeguarding practice concerning children and young people is directly transferable to adults.

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

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.[10] 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. It will include a consideration of compatibility. The RQIA has a duty to regulate the whole service. Care homes are responsible for supplying what is specified in contracts and in residents' care plans within the law and regulations under which they are governed.[11]

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[12] - 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 evidence 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[13] 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

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

[11] 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

[12] 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)

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

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.

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 as being a part of a good life;
- improving the relationships with residents and their families and establish their role in caring and supporting the resident – sharing the care 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,"[14] 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

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

signals."[15] 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, 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.[16] The Review Team's proposed action is based on knowledge about the importance of the six senses[17] – 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.

Concluding Statement

15. Life in a care home is about more than staying alive and being safe. The bleak experience of residents and their families at DMCH confirms that these are prerequisite. Care homes require the continual involvement of residents and their families if a more grounded consideration of what constitutes good care is to result.
16. 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.

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[15] 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.

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

[17] *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