COPNI Commissioner for **Older People** for Northern Ireland

The Commissioner's view:

A summary of the responses to *Home Truths*

January 2020

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Commissioner's foreword

Since the publication of the *Home Truths* Report in June 2018, my team, expert panel and I have been working with the authorities that were subject to the investigation into failings at Dunmurry Manor Care Home in Belfast. The recommendations outlined in *Home Truths* aimed to address the serious and systemic failures that had permitted inhuman and degrading treatment of older people.

My recommendations called for reforms that, if implemented, would ensure that families with concerns about any aspect of care would feel empowered to raise their concerns in a responsive and sympathetic environment. They also called for changes to how the workforce in care settings are supported so that they can better provide the high level care that older people deserve.

A total of 59 recommendations were made to the seven relevant authorities, culminating in over 400 responses being received by my office. Given the complexity of the investigation, the purpose of this report is therefore to provide a summary of the responses under each of the nine themes. This report is split into nine 'chapters' – one chapter for each theme. In each, I refer to the recommendations made under each theme and offer my view on the overall response received. (A full list of the recommendations can be found on pages 19 - 27) Additionally, the full detail of the responses received by my office from the relevant authorities is available on COPNI's website should you wish to read this in-depth.

I am pleased that the majority of my recommendations have been accepted. However, while commitments on paper are welcome, I will only be satisfied that lessons have been learned and solutions put in place once there is evidence that changes have been implemented and been effective on the ground. I understand that it takes time to bring about changes to legislation, policy and practice but I remain frustrated with the pace of change in many areas where my investigation found flaws in the system.

I remain deeply concerned about the effectiveness of the handling of complaints at local and regional level. Recent direct evidence from families of residents in other care homes highlights that frustrations remain for many families when their concerns are not being adequately responded to. The experience of the families of residents remains the strongest advocacy for the needs of their relatives and many families continue to be tenacious, resolute, and compassionate in demanding the appropriate levels of care for their relatives living in care home settings. However, as admirable as this is, it simply should not require such persistence to secure adequate care for older people in need. Those with the power to effect change need to take action to address the inadequate complaints system currently in place.

Care home providers have primary responsibility for the care of those in their homes, but the accountability for the safety

and wellbeing of older people in care homes rests with the Department of Health and its arm's length bodies which place older people in these homes.

While I understand that there are many challenges that the health authorities are dealing with at this time, the care and safety of older people living in care homes needs to be a top priority for the Department of Health and all of the relevant authorities tasked with ensuring good standards are met. It is therefore vital that the recommendations in *Home Truths* are implemented as soon as possible.

There must be clear and unambiguous accountability for the delivery of adequate, effective and safe care for older people. I remain committed, along with the rest of the COPNI team, to doing everything in my power to drive forward the changes needed to ensure that older people across Northern Ireland receive the quality of care that they require and deserve.

I would like to thank my expert panel of advisors, Eleanor Hayes, Dr Robert Peat and Professor John Williams for their expertise and invaluable input throughout the course of this investigation.

Finally, I would like to thank all the families and friends of residents of Dunmurry Manor for their patience and support whilst I carried out the investigation and during the post-publication stage. Since the publication of *Home Truths* my office continues to be contacted by many families of older people who have reached out for assistance in relation to concerns about their loved one's care. Many older people have also expressed relief that this issue is being scrutinised and hope that as a result it will lead to better protection and care standards in future.

Eddie Lynch
Commissioner for Older People for Northern Ireland

Introduction

On 13 June 2018, the Commissioner for Older People for Northern Ireland published *Home Truths – A Report on the Commissioner's Investigation into Dunmurry Manor Care Home*. The report made 59 recommendations to seven Relevant Authorities (RAs) with the overarching aim of improving the standard of care provided to older people in care home settings.

The 59 recommendations related directly to the investigation findings and were categorised under nine key themes;-

- Safeguarding and human rights
- Care and treatment
- Medicines management
- The environment and environmental cleanliness
- Regulation and inspection
- Staff skills, competence, training and development
- Management and leadership
- Complaints and communication
- Accountability and governance

Since the publication of *Home Truths* there have been a number of developments in relation to care homes. These include investigations by other agencies into what happened at Dunmurry Manor Care Home (DMCH). This response from key authorities to the serious findings uncovered by the Commissioner's investigation was welcome and it is understood that a number of these remain ongoing. In order to avoid any further delay in providing an update to families and other interested parties, the Commissioner considers that this update marks the end of his investigation process.

Ongoing liaison with CPEA

The Department of Health appointed CPEA Ltd to carry out an independent review of the systemic failures highlighted by the Commissioner's investigation. This review was not a re-examination of the investigation, rather it was intended to provide advice to the Permanent Secretary on the weaknesses of the current system that led to the circumstances at DMCH and across the HSC system.

At the request of the Independent Review Team (the IRT), the Commissioner, the Chief Executive and members of the COPNI team met with them on a number of occasions over the year following their appointment. On each occasion the IRT consulted with COPNI on their ongoing work.

The Commissioner looks forward to publication of the IRT's report in full and all of its advice to the Department of Health.

Post publication: the process

Following publication of the investigation report in June 2018, the RAs were required to submit responses to the recommendations within three months. This deadline was 1 October 2018 and the responses were to set out whether the RAs accepted the recommendations and, if so, how they proposed to implement them. Responses from all RAs were received within the prescribed timeframe.

The responses were reviewed and discussed at several meetings with the Commissioner's appointed expert panel, and the investigation team. This part of the process determined

whether or not the responses provided were "adequate" (this term is specifically used in the COPNI Act 2011). Following this analysis, it was determined that further information was required in respect of a number of the recommendations and from a number of the RAs.

Current context

Under the terms of the COPNI Act 2011, the Commissioner wrote to the RAs at the end of May 2019 requesting additional information on some aspects of their responses. This part of the process allowed them a further month to provide this information.

Runwood Homes provided the additional information sought by the date requested. The Department of Health wrote to the Commissioner in July stating that it was overseeing a single composite response to the Commissioner's recommendations i.e. it was co-ordinating the response from the Department of Health, the RQIA and the four Health Trusts involved in the investigation. The Department of Health requested an extension until the end of September 2019 to provide the additional information requested and this was accepted in the interests of getting the most comprehensive response possible. Responses were received on 8 October 2019.

The information that follows is a summary of the responses received in line with the chapters of the *Home Truths* report.

1. Safeguarding and human rights

The Commissioner's *Home Truths* report made seven recommendations for change under this theme.

These recommendations centred around the need for adult safeguarding legislation in Northern Ireland and the duties which would flow from it.

The composite response from the Department of Health focuses on the need for a Minister to be in place in order for legislation to be developed and for guidance on the use of CCTV in care settings to be taken forward.

One of the issues raised by the Commissioner, when the first round of responses was received, was the absence of any details on specific timeframes for the implementation of some of the recommendations.

The October 2019 response did provide further information. It reiterated the requirement for a Ministerial decision, but stated that preparatory work has commenced and that consideration is being given to whether or not a public consultation exercise could proceed before the restoration of an Assembly and Executive.

For the most part, the other RAs appear to agree with the Commissioner's recommendations on this theme. The individual responses demonstrated a written commitment to ensuring that all staff would receive appropriate training in the human rights implications of their work and that this is an essential part of current training.

The RQIA's response discussed plans in place to review its inspection methodology, receiving training on human rights and a planned review of registration processes to be aligned with the overarching review of inspection methodology. It also made reference to benchmarking with the Welsh regulator and the Care Quality Commission as part of their review of inspection methodology.

The Department of Health and RQIA's responses make reference in a number of places to relying on the advice that is coming from the work of the Independent Review Team (IRT) and an intent to progress the implementation of the Commissioner's recommendations based on the report or advice from this team. Whilst COPNI has met with the IRT and is supportive of this work, the details of all of their work, any written report, detailed advice and recommendations remain unknown at this time.

The Commissioner's view:

Northern Ireland remains the only part of the UK where older people do not have adequate law to protect them.

I welcome the pre-legislative work on this as the introduction of an Adult Safeguarding Bill must be a top priority for our new Minister of Health.

I welcome the acceptance from authorities that there are significant flaws in the operation of the safeguarding policy and the joint protocol between police and social services and the commitment to strengthen these policies.

I welcome the commitment to embed human rights training across all staff who work in the care home sector.

However, more comprehensive guidance on CCTV use in care homes must be developed as a matter of urgency.

2. Care and treatment

The Commissioner's *Home Truths* report made eight recommendations for change under this theme.

These focused on the need for the fundamentals of good nursing and social care to underpin the delivery of all aspects of care. They emphasised the need for all care to be safe and effective and delivered by caring and compassionate professionals with up-to-date knowledge and skills, in an environment where they are helped and supported to do what they need to do for residents.

These recommendations also reiterated previous recommendations on the reporting of SAIs[1], failure to make proper reports and the need for improvement in the use of information available to and from families of residents in care settings.

The first round of responses from the Health and Social Care (HSC) bodies lacked sufficient information for the Commissioner to understand whether the RAs actually accepted the recommendations that had been made as well as details about how and when the changes would be implemented.

After requesting further information on the nature and scope of the work referred to in the responses, including proposed plans and timeframes, the next set of responses received did go further in order to provide more information for the Commissioner to be assured.

This brought an added complexity to analysing the responses and there are a number of the recommendations in this theme which the RAs have "partially accepted" and a number which have overtly been "not accepted." In respect of the introduction of a ratings system, the The Department of Health states that it has *"considered this recommendation and formulated advice for an incoming Minister."* For R10 and R11 the The Department of Health "noted" these, rather than "accepting" them [2].

The Commissioner's view:

I welcome the following commitments by authorities:

- RQIA to involve families more in inspections;
- improve monitoring of residents being moved out of homes by families;
- gain better intelligence on the reason for residents being moved; and
- gathering better information for families deciding on care home placements.

However, there remains a lack of detail about this work and its outcomes to date. I will be seeking further information on these commitments with our new Minister of Health. I welcome the response and evidence provided by Runwood Homes illustrating changes of policy, workforce and operational guidance. It will take time to establish if these are effective in sustaining improvements in care and safety.

I will continue to work with individual people who have concerns about their relatives in care homes, and highlight the difficulties they are experiencing. I will require RAs to act swiftly and effectively to resolve issues where they arise.

[1] Serious Adverse Incidents

[2] R10 and R11 were both a reiteration of recommendations made in the Hyponatraemia Inquiry on SAIs

3. Medicines management

The Commissioner's *Home Truths* report made six recommendations for change under this theme.

Ineffective medicines management led to a number of residents displaying physical and emotional behaviours that harmed themselves or others. If medicines were being managed as they should be, then none of the recommendations in this theme would have been necessary.

The recommendations ranged from the requirement for better medicines management and record keeping to a statement of an unequivocal need for residents to receive prescribed medications as directed. They also included the need for appropriate audit and inspection of medicines.

The recommendations were directed to Dunmurry Manor / Runwood, all care providers and to the RQIA.

For the most part the recommendations have been accepted by the RAs to which they were directed.

R16 was accepted by Runwood Homes and it provided commitments to the introduction of updated medicines management systems and their plans for audit and review.

The RQIA's response focused on R21 and outlined that "medicine incidents continue to be reviewed by a pharmacist inspector when received into RQIA. Inspectors will contact the home if necessary to ensure appropriate action has been taken. They also identify any developing trends in the incidents reported. Prior to any medicines management inspection the notifications received since the previous medicines inspection will be reviewed as part of the pre inspection preparations."

The RQIA's response further outlined that any reported issues about a home are discussed during the inspection to ensure that staff have identified any trends and are aware of the incidents that have occurred.

In addition, both the Department of Health and RQIA responses refer to the review of notifiable incidents "continuing" to be a component of inspection planning and inspections. The Commissioner requested clarity, in May 2019, as to whether the recommendation was accepted or not and how the RQIA has developed its practice to ensure it reviews all notifiable incidents. R21 has not therefore been "accepted".

Although the text of the response suggests that the review of notifiable medicines management incidents is happening in the normal course of inspections, this recommendation has not been formally accepted by RQIA.

RQIA provided no information on changes in their inspection practice to address the findings in this theme. The Department of Health and the Belfast HSC Trust explicitly accepted this recommendation.

The Commissioner's view:

I welcome the introduction of a monitoring dosage system in DMCH to help reduce medication errors.

I welcome the commitments provided to:

- review medication when older people are moved settings;
- involve families more in any medication changes;
- establish a medications audit with pharmacists; and
- focus on better record keeping of medications

I will be seeking regular updates on these commitments during 2020 and beyond.

4. The environment and environmental cleanliness

The Commissioner's *Home Truths* report made six recommendations for change under this theme.

The recommendations made under this theme ranged from building requirements meeting the Dementia Friendly standards to hygiene and cleanliness of care settings and the need for devolved budgets for goods and materials which was accepted by Runwood Homes.

Again the recommendations made were directed to DMCH / Runwood Homes, the RQIA and to the Department of Health as a range of the changes being recommended would be relevant to any setting providing care to older residents. Although the recommendations made under this theme seemed relatively straight-forward, it seems that a number required a Minister to be in office for progress to be made on an introduction of new standards. The Commissioner interpreted the response to R28 on the need for integrated inspections as general acceptance but there is an absence of detail on progress against implementation of the recommendation.

The Commissioner's view:

There needs to be a stronger commitment to making inspections of residents' rooms a more integral part of RQIA Inspections.

I believe 'dignity and respect spot checks' should be introduced immediately as an additional safeguard to protecting older people in care settings.

I welcome the commitment to advise the new Minister of Health on the need for more Dementia Friendly standards for care homes.

5. Regulation and inspection

The Commissioner's *Home Truths* report made 10 recommendations for change under this theme.

A very significant finding from the investigation (and from ongoing casework brought to COPNI) is a wide disparity between the information and evidence being brought to COPNI and the experience of the RQIA when carrying out inspections.
This theme of the *Home Truths* report was the longest and most difficult to address.
The recommendations made were directed to either the Department of Health, the HSC "system" or to the RQIA directly. During the investigation, the expert panel of advisors to the Commissioner described the pattern of inspections undertaken by the regulator as a type of "management by inspection" as during the period of the investigation there were 23 inspections (over 3.5 years).
The Commissioner also believed that the length of time allowed for improvements in care to be made was too long, with failure to comply notices issued in October 2016 which were not lifted until after the inspection of July 2017 – more than nine months after the issues highlighted by the October 2016 inspections.

It was also the case that none of the inspections were carried out during the night or at weekends. A number of witnesses described holiday periods and weekends as times when they felt at risk or unsafe with the circumstances in the Home.

It was very clear to the Commissioner that the RQIA was concerned about care and safety at DMCH and was not completely satisfied that it met the required standards. The HSC Trusts also had concerns and shared these with the RQIA.
In light of all of the concerns raised with regard to inspection and regulation during the investigation, the recommendations made by the Commissioner under this theme were greater in number and in scope, covering;-

- Integrated inspections
- Collaborative working across the system to turn around a failing home
- Review of inspection methodology
- Need to engage with staff and families as part of the inspection
- Use of lay assessors in the inspection of homes
- Strict time limits for improvements
- Night-time and weekend inspections as normal part of the inspection regime
- Introduction of a performance ratings system / grading system
- Strengthening financial penalties
- RQIA's role in ensuring complaints are actioned.

The responses from the RAs to the recommendations made under this theme were broadly accepted, although a degree of difference is apparent.

Runwood Homes' response to the recommendations which fall under this theme, outlined a general commitment to adhere to any change or direction coming from the Department of Health or the RQIA.
The issue of the appropriate and consistent management of complaints made as a result of experiences of care settings remains a concern and is a key priority for the Commissioner as issues continue to be brought to the attention of his office.
In the period since publication, COPNI continues to meet with NIPSO[3] and the PCC[4] to ensure that the intelligence coming from complaints is captured and used to effect positive change.

R30 – the review of inspection methodology and R31 – inspector engagement with staff and R32 – use of lay assessors and R34 –

use of night-time inspections, have all been accepted by the RQIA. Whilst four out of 10 recommendations have been accepted by the RQIA, the composite response from the Department of Health refers to the need for a Minister to be in place for progress to be made on introducing a performance rating system, the strengthening of financial penalties for poor performance and the role of the RQIA in taking action on complaints. While it is welcome that the RQIA has accepted a number of the recommendations directed at it, the Commissioner remains concerned with the lack of response from the RQIA on a number of important issues. A number of the responses in the composite response appear to be the Department of Health replying on behalf of the RQIA and the response doesn't contain any direct statements from the RQIA on issues that fall within its remit. The Commissioner believes that the recommended changes needed to the regulation and inspection system are fundamental to ensuring older people are better protected in future. The Commissioner needs further assurances from RQIA that it accepts the flaws in the current regulatory system and that it is fully committed to implementing the relevant recommendations for RQIA contained in the *Home Truths* report.

The Commissioner's view:

I welcome the acceptance that significant changes are required to the regulation and inspection process.

I welcome the commitments to:

- More integrated inspections
- A review of the complaints system
- A review of the RQIA inspection process
- Use more lay assessors to be used in care homes
- introduce a target where 20% of inspections in care homes are conducted at night or at weekends.

While these commitments are welcome, I will only be assured once I see evidence that these changes have been implemented in full.

I accept that our new Minister of Health will have to consider the following and welcome that this advice is being developed.

- Rating system for care homes
- Stronger financial penalties for providers who don't meet minimum standards of care
- The role of the RQIA in a new complaints process.

[3] Northern Ireland Public Services Ombudsman
[4] Patient and Client Council

6. Staff skills, competence, training and development

The Commissioner's *Home Truths* report made seven recommendations for change under this theme.

All of these recommendations were made in the knowledge that there is an ongoing and unprecedented shortage of nurses and other care staff both in the NHS and in the independent sector.

The *Home Truths* report also emphasised the fact that professional bodies such as the RCN[5] and others have been campaigning for decades for improved workforce planning and direction from successive governments. In this context, the challenges of recruiting and maintaining a stable nursing workforce within both the statutory and independent sectors has been increasing year on year. The complexity of care required by older residents in care settings is also increasing and necessitates safe and compassionate nursing with expertise in a wide spectrum of specialisms. The investigation highlighted the challenges of recruiting and retaining staff with all of these skills in the independent sector.

The other major challenge highlighted by the investigation is that of staffing levels. There are no defined "normative staffing levels" for care settings in the same way as there would be in hospitals. Instead, staff numbers and skills mix are to be determined by the needs of the residents living in the setting at any given time.

In reality, this means that managers in care homes must make decisions on a daily basis about numbers of staff needed to ensure competent patient care and safety. This presents more challenges in the independent sector where terms and conditions may not be as attractive to workers as opportunities to work in the HSC Trusts.

Of the seven recommendations made, a number were directed primarily at the Department of Health, some were directed at the RQIA and others at Directors or Heads of Nursing within the HSC Trusts or care settings. Again, for the most part the recommendations were accepted by the RAs. Within this theme, however two HSC Trusts did not accept R42, which recommended that Trust Directors of Nursing should "ensure" adequate cover via their contract arrangements. This suggests a divergence of acceptance between the Department of Health composite response and the position of the HSC Trusts. The Commissioner requires the Department of Health to explain how that will be resolved.

The Commissioner's view:

I welcome the commitments on workforce reviews to ensure the care industry can have the skills and expertise it needs to meet the needs of our ageing population. I will seek regular updates on the progress of these reviews and the difference they are making for providers of care.

It is vital that providers take appropriate steps to assure families that a care home has the necessary staffing numbers and competence to fully meet the needs of residents. More needs to be done to monitor staff attrition levels and appropriate action must be taken by authorities if there are concerns about the impact of high staff turnover on the quality of care.

[5] Royal College of Nursing

7. Leadership and management

The Commissioner's *Home Truths* report made four recommendations for change under this theme.

One of the findings underlined the reason for many of DMCH's issues. Over the relevant 3.5 year period, it had 10 different managers in post. Relatives reported finding this rapid turnover of management very frustrating and contributing to inconsistencies in care, low staff morale and poor performance in terms of implementing improvements when they tried to make complaints.

Staff who had worked in the home reported difficulties with senior staff in the wider corporate organisation and relationships became more difficult between the South Eastern Health and Social Care Trust (SEHSCT) and Runwood Homes as concerns over the level of manager and staff turnover were highlighted.

The recommendations in this theme also addressed what the Commissioner believes to be a gap in current arrangements for people who wish to raise concerns, or "whistle blow" from within and feel unable or unsupported to do so.

The fear of repercussions if people choose to raise issues or complaints is a concern which was apparent in the investigation and remains a feature of the Commissioner's casework. This concern is expressed by families who fear the potential for repercussions with regard to their relatives' care and from staff in relation to their own individual work circumstances and job security.

There are three recommendations within this theme which the Department of Health has asserted would require a Ministerial decision. These are:

- Changes to the fit & proper person assessment by RQIA as part of the registration process.
- An independent body to encourage and support whistle-blowers.
- The role / responsibility for unresolved family complaints (HSC Trust or RQIA).

The RQIA response was largely silent on a number of the recommendations where the Commissioner sought additional information or clarification on whether they were accepted or not accepted. For this theme the RQIA and Trusts responses indicated that they would implement any changes to their role and function that any new legislation or departmental policy change would require.

The Commissioner's view:

The responses indicate that many of the changes needed in leadership and management requires Ministerial approval.

These issues therefore need to be outlined immediately to our new Minister of Health:

- changes to the 'fit and proper person assessment';
- the establishment of an independent body to encourage and support whistleblowers; and
- complaints' system changes to identify the roles and responsibilities of authorities in handling complaints from families.

These issues remain outstanding and must be progressed as soon as possible.

8. Complaints and communication

The Commissioner's *Home Truths* report made six recommendations for change under this theme.

These ranged from recommendations to address the complexity of the complaints processes to issues around candour and where the accountability for dealing with complaints should sit.

There are two recommendations within this theme which the Department of Health reported would require a Ministerial decision. These are:

- central collation of complaints and annual reporting; and
- a shared or central point of access for complaints.

The composite response, signed off by the Department of Health, indicates that the Commissioner will have full sight of the report from CPEA, part of which will consider effectiveness of communications across the HSC. The Department of Health has asserted that there will be no ambiguity in complaints processes in relation to which body has responsibility for capturing complaints, leading on resolution and escalation if needed. The Department of Health committed to complete the work by June 2020.

The Commissioner's view:

I welcome the commitment to review the overall complaints' system which will be completed by June 2020. However, further detail on the key milestones for this work needs to be made available.

The complaints' system in relation to care homes requires a fundamental overhaul as it is not currently fit for purpose and does not provide families with the support and response they need if they are concerned about a relative's care.

The establishment of a more responsive and effective complaints system is central to changing the culture within the care sector and to empower families to take action on any concerns they may have.

9. Accountability and governance

The Commissioner's *Home Truths* report made five recommendations for change under this theme.

These focused on the commissioners of care contracting with providers who have strong systems of governance, reviewing the regional contract and the need for clear escalation policies for all RAs.

With 90% of all care home placements provided by the independent sector, it is essential that homes and their parent companies are properly accountable for the standards of care and operate within appropriate governance frameworks. The Department of Health committed to setting up a HSC wide working group to respond fully to R55. They confirmed communication was a likely area of focus for the independent review team and will consider all "pertinent" recommendations. The composite response from the Department of Health passes primary responsibility for governance and accountability for commissioned services to the HSC Trusts. All Trusts with the exception of South Eastern Trust accepted this recommendation. SEHSCT "partially accepted" the recommendation. The overall tenor of the Department of Health's response was that it was content that current arrangements already addressed governance and accountability requirements. However, these arrangements clearly failed to protect older people at DMCH.

Despite the Department of Health's assertion that the work ongoing in workstream one of the Hyponatraemia implementation programme is developing options in relation to the recommendations on a duty of candour, no details of how this would be done were provided.

The Commissioner's view:

There is clearly much improvement needed to 'joined-up working' between the various authorities tasked with ensuring older people living in care home settings are protected.

I welcome the commitment of authorities to improve escalation policies and communication channels on care issues but evidence will need to be provided to show what has changed and what effect the changes are having in protecting older people.

It is vital that the duty of candour recommendation from the Hyponatremia inquiry is progressed as a matter of urgency by our Minister of Health.

I welcome the review of the regional contract with the care home industry too and will seek updates on this on a regular basis.

Looking ahead

This update has provided a summary of the responses received to the 59 recommendations made by the Commissioner and an overview of progress across each of the nine themes included in the *Home Truths* report.

The Commissioner believes that most of the Relevant Authorities have responded in a generally positive tone and welcomes the acceptance of the majority of the recommendations and the commitments to implement them.

However, a number of the responses do not provide the assurances needed that action has been taken to ensure that the failures that occurred in DMCH cannot be repeated. The commitments given by authorities to making progress are welcome but sustained effort and prioritisation will be needed going forward to ensure the recommendations are implemented in full.

The Commissioner acknowledges that making progress on a number of the areas for change is not straightforward and will take time but it is vital that every effort is made to progress these as soon as possible. The Commissioner expects to meet our new Minister of Health very soon to ensure that these matters are progressed as a matter of urgency.

The Commissioner wishes to assure older people that although the investigation process concludes with this report, the matters arising from it will continue to be a key focus of his office. The Commissioner and his expert panel agreed that focus should be concentrated in five specific areas moving forward. These are:

- Regulation and inspection
- An Adult Safeguarding Bill
- Complaints system
- Staffing levels
- Fit and proper person test

The Commissioner will consider how these matters will feature in the ongoing development of his next corporate plan in 2020. He will consider the use of all his powers to advise our new Health Minister on prioritising the essential reforms required.

Older people in Northern Ireland have a right to be protected and to receive the highest standards of care at all times. The Commissioner and his team will continue to seek progress on the implementation of all of the *Home Truths* recommendations to ensure that this happens.

*** The responses received from each Relevant Authority are available on the COPNI website as well as the register of the statutory recommendations as outlined in Schedule 2 (4)(5) of the COPNI Act (Northern Ireland 2011).**

Recommendations

Safeguarding and human rights	
R1	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.
R2	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 an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries.
R3	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.
R4	Practitioners must be trained to report concerns about care and treatment in a human rights context.
R5	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.
R6	The registration and inspection process must ensure that care providers comply with the legal obligations imposed on them in terms of human rights.
R7	The Department of Health 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.

Care and treatment	
R8	HSC Trust Directors of Nursing, as commissioners of care in the independent sector, should assure themselves that care being commissioned for their population is safe and effective and that there are systems to monitor this through the agreed contract between both parties.
R9	There should be meaningful family involvement in care and treatment plans and decision making at all key milestones. Electronic or written care plans should be available to families on request, including nutritional information.
R10	The Commissioner reiterates Recommendation 4 of the Inquiry into Hyponatraemia-related Deaths that, "Trusts should ensure that all healthcare professionals understand what is required and expected of them in relation to reporting of Serious Adverse Incidents (SAIs).
R11	The Commissioner reiterates Recommendation 32 from the Inquiry into Hyponatraemia-related Deaths that Failure to report an SAI should be a disciplinary offence.
R12	Failure to have an initial 6 week care review meeting should trigger a report in line with SAI procedures
R13	The RQIA should pro-actively seek the involvement of relatives and family members as well as explore other routes to getting meaningful information, data and feedback on the lived experience in a care setting.
R14	The movement of residents by relatives to other care homes should be viewed as a red flag and feedback should be obtained by the commissioning HSC Trust and the RQIA on the reasons for such moves.
R15	There should be adequate support and information provided to older people and their families when facing a decision to place a loved one in a care home. Each HSC Trust should allocate a senior health professional to oversee these placements and good practice. This would be greatly helped by the introduction of a Ratings System for care settings.

Medicines management	
R16	Dunmurry Manor should consistently use a Monitored Dosage System for medicines administration which would prevent many of the errors identified in this investigation for the administration of regular medications.
R17	Care must be taken by staff to ensure any medicines changes, when being admitted / discharged from hospital, are communicated to the medical prescriber in order to institute a proper system to identify and amend any errors.
R18	Families of residents must have involvement in changes in medication prescribing. Explanation should be provided so that resident and family members understand the reasoning for any change.
R19	Staff should ensure it is clearly documented on each occasion why a resident might not be administered a medication.
R20	A medications audit must be carried out monthly or upon delivery of a bulk order of medication. This must be arranged with a pharmacist. To assist with more effective medicines management, providers of care homes should consider contracting with their community-based pharmacist (for a number of hours each week) to ensure that medicines management is safe and effective. The pharmacist could assist in staff training, identify where there are competency issues in the administration of medications and improve medicines governance within the home.
R21	The RQIA Pharmacist Inspectors need to review all medication errors reported since the previous inspection and review the Reg 29 reports in the home to ensure steps have been taken to improve practice.

Environment and environmental cleanliness	
R22	It must be a pre-registration requirement for RQIA and a pre- contract requirement for HSC Trusts that all new Care Homes specialising in dementia care comply with Dementia Friendly building standards [and that buildings already in place are subject to retrospective “reasonable adjustment” standards].40 This must form part of periodic inspections to ensure suitability is maintained.
R23	Premises must be one of the areas that RQIA Inspectors routinely inspect as an integral part of an integrated inspection with a focus on the condition of residents’ rooms.
R24	Runwood must devolve goods and services budgets to a local level for staff to manage.
R25	The RQIA must review how effective inspections are for periodically covering all of the Regional Healthcare Hygiene and Cleanliness Standards and exposing gaps that a home may have in relation to these.
R26	Consideration should also be given to expanding these Standards in line with the NHS ‘National Specifications for Cleanliness’, which emphasise additional issues like the Cleaning Plan of the Home and a specified standard of cleanliness for different parts of the home/ different types of equipment.
R27	The programme of unannounced ‘Dignity and Respect Spot Checks’ should also include assessment of the suitability and state of the environment. In Dunmurry Manor the breaches of key environmental indicators raise the question of whether residents were being treated with appropriate dignity and respect and whether this should have triggered warning signs about Dunmurry Manor at an earlier stage.

Regulation and inspection	
R28	Integrated inspections which cover all of the lived experience of residents should be introduced by the RQIA as soon as possible.
R29	A protocol for collaborative partnership working in improving care in a failing care home should be developed and implemented as a matter of urgency by the RQIA and the HSC Trusts. The protocol should address the handling of complaints and the use of intelligence deriving from these to better inform all those with responsibility for the care of older people placed in homes.
R30	RQIA need to review their inspection methodology in order to access reliable and relevant information from residents and their families.
R31	RQIA inspectors must engage effectively with staff, especially permanent staff, in order to glean a more comprehensive view of the home being inspected.
R32	The use of lay assessors / inspectors in the inspection of care settings for older people should be introduced.
R33	There should be a strict limit to the length of time a home is given to make improvements to bring its service back into full compliance.
R34	The RQIA should implement an inspection regime which includes weekend and night-time inspections for all homes on a more regular basis (and at least once per year), especially where there are indications of problems within a home. This offers an opportunity to reflect on the management of night time and weekend needs when fewer staff may be present and residents may present with more challenging behaviours.
R35	The DoH / RQIA should introduce a performance rating system / a grading system, as is the practice in other jurisdictions of the United Kingdom as soon as possible.
R36	The system of Financial Penalties should be strengthened and applied rigorously to care settings which exhibit persistent or serious breaches of regulations.
R37	The RQIA should have a statutory role in ensuring that complaints are actioned by care providers to the satisfaction of complainants.

Staff skills, competence, training and development	
R38	The Department / Chief Nursing Officer as the commissioners of pre-registration nurse education should ensure workforce plans are developed that take cognisance of nurse staffing requirements for the independent sector.
R39	The Chief Nursing Officer (CNO) as a matter of priority should undertake a workforce review and commission work to design tools to measure nurse manpower levels required in the independent sector in Northern Ireland ie normative staffing level guidelines and the minimum standard staffing guidance revised accordingly.
R40	The RQIA should collaborate with the CNO in this work and revise the minimum nurse staffing standard No 41 to give more clarity to the independent sector on levels of nurse staffing which are required to deliver safe, effective and compassionate care.
R41	A high level of staff turnover and use of agency should be considered a “red flag” issue for commissioners of care and the RQIA. Such findings should trigger further investigation. The Nursing Home Minimum Standards on staffing should reflect concerns where there is a high staff turnover and state that exit interviews are required in the event of any staff terminating their contract with a provider.
R42	Trust Executive Directors of Nursing should ensure as commissioners of care in the independent sector that there are sufficient numbers of nursing staff to deliver safe, effective and compassionate care in the sector and assure themselves through the contract agreements with providers.
R43	The RQIA inspection process must review levels of permanent staff attrition as well as the balance of agency / permanent staffing levels across all shifts in place in a home and should review exit interviews.
R44	Runwood Homes must carry out an urgent staffing review to address weaknesses in induction, to investigate the high levels of attrition of nursing staff and managers in Dunmurry Manor and to make improvements to workforce management to encourage retention of permanent nursing staff and managers.

Management and leadership	
R45	The RQIA should require managers leaving employment with a home to provide them with an exit statement, within a defined timeframe, to enable them to identify patterns or issues which should trigger an inspection. Exit statements would be treated in confidence (and not available to the employer).
R46	Any reports of inappropriate behaviour by senior managers in the sector should be investigated in full by the HSC Trust (at a contract level) and by the RQIA (in terms of the registered individual status). The outcome of these investigations should be a material consideration for the RQIA in terms of the "Fit and Proper Person" test.
R47	An independent body should be established to encourage and support whistleblowers throughout the process and whistleblowers need to be protected by the law to make genuine disclosures.
R48	Relatives / residents who raise concerns which are not resolved locally should have their complaints handled by the commissioning HSC Trust or the RQIA (See Section 8 on Complaints and Communication).

Complaints and communication	
R49	Dunmurry Manor / Runwood must introduce an open and transparent complaints management system and welcome the early involvement of families and relatives in complaints resolution. Families should be well informed at all times of the next steps in the complaints process.
R50	There must be improved communication between all bodies receiving complaints. Central collation would enable complaints to act as a better 'Early Warning System' about a failing home. A requirement for annual reporting of numbers and types of complaints, how they were dealt with and outcomes, would be a first step towards more open and transparent communication about complaints.
R51	Given the poor information sharing over the issues in Dunmurry Manor, there should be a central point of access where the RQIA can access all complaints made to the home, not just to it. They must then use this access to track patterns, and look at the detail of complaints that are indicative of serious concerns.
R52	Complaints statistics relating care homes should be published annually and be made publicly available, subject to adherence to appropriate data protection protocols.
R53	A Duty of Candour (see Section 9) must be introduced to provide a transparent and meaningful learning process from complaints.
R54	In the event of a complex and serious complaint not being resolved locally, an independent complaints process should be engaged that allows access to alternative dispute resolution, providing appropriate support for whistleblowers and families.

Accountability and governance	
R55	The sharing and analysis of communication regarding concerns about low standards of care must be improved within and between the HSC Trusts, the RQIA , including its Board and the Department of Health to enable a more efficient and effective information flow, action and follow-up in all matters pertaining to failures of care.
R56	Those who commission care should assure themselves that they contract with organisations which have strong governance and accountability frameworks in place. Record keeping should be subject to rigorous and regular audit.
R57	An individual Duty of Candour should be introduced in Northern Ireland for all personnel and organisations working across and in the system which governs and delivers care to older people to encourage openness and transparency.
R58	The Regional Contract should be reviewed and training provided in relation to its content and the effective use of its terms. The Department of Health to conduct a review of why/ whether this contract is adequate in terms of being able to enforce the performance obligations contained therein.
R59	All Relevant Authorities should develop and implement Escalation Policies that ensure senior officials are sighted in operational matters that are serious, protracted or otherwise significant in their business area.

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