



Commissioner for **Older People**
for Northern Ireland

Changing the culture of care provision in Northern Ireland

Commissioner's Advice to the Minister for Health,
Social Services and Public Safety

November 2014

The report is available in other languages and formats on request.
Also available for download at www.copni.org



Changing the culture of care provision in Northern Ireland - Commissioner's
Advice to the Minister for Health, Social Services and Public Safety

Published by The Commissioner for Older People for Northern Ireland

November 2014

© The Commissioner for Older People for Northern Ireland copyright 2014

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit www.nationalarchives.gov.uk/doc/open-government-licence or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

ISBN: 978-0-9930725-3-6

Contents

	Page
1. Executive Summary: Commissioner's Proposals	2
2. Context	5
3. Care standards and inspection processes	9
4. Enforcement	19
5. Whistleblowing and protection	30
6. A cultural change in care	33
7. Conclusion	41
Summary: Recommendations from the Independent Review and the Commissioner's Advice for a whole-system change	42
8. Stakeholder List	44

1. Executive Summary

- 1.1 It is important that older people and their relatives in Northern Ireland have confidence in the system and delivery of regulated care services. Recent approaches to the Commissioner's office, the casework managed by the office and the recent Independent Review of the *"actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus"*, have highlighted significant failings in the level of care provided, as well as consistent failings in the protection of vulnerable older people and 'whistleblowers'. The examples show that unacceptable practices and systems exist in care services. These failings must be urgently addressed so that older people can have confidence that they will enjoy an acceptable standard of care should the need arise.
- 1.2 This document contains advice to the Minister for Health, Social Services and Public Safety (HSSPS) on the steps which the Commissioner believes need to be taken in order to better protect older people in regulated care settings across Northern Ireland and to improve the services they receive. The advice includes:
- i) Changes needed in the regulation and inspection processes,
 - ii) Workforce issues and staff development,
 - iii) Protection and support for whistleblowers and,
 - iv) The strengthening of contracts under which an older person lives in either nursing or residential care home facilities.

A summary of the initial comment made in August 2014 for improvements needed in the regulation, inspection and delivery of care is as follows:

Care standards and inspection processes

1. The rights, quality of life, dignity and care needs of vulnerable older people should be at the heart of planning, delivery, regulation and inspection of care services; it is their needs that must matter the most.
2. Standards for the care of vulnerable older people should be clearly displayed and available to all service users and their families and relatives for all nursing, residential and domiciliary care services as well as for any prospective users.

3. Inspection processes should be rigorous, with decisive and timely enforcement action when failings are detected.
4. The regulation and inspection service should include a rating system for care homes and domiciliary care services. In addition to an overall rating, it should clearly identify if there are any breaches of regulations or failures to comply with improvements required.

Enforcement

5. There should be clear and rigorously applied sanctions taken against care providers for non-compliance with the minimum standards.
6. Persistent or serious breaches of regulation and/or compliance should result in decisive sanctions being applied without delay and within a defined timeframe. The sanctions that should be applied include de-registration of owners and managers; home closure; financial penalties; suspension of new admissions to care homes and domiciliary care services.
7. Health and Social Care (HSC) Trusts should not continue to place vulnerable older people in nursing and residential care homes, or with domiciliary care services, where there are unresolved compliance failures and unacceptable standards of care.
8. New legislation to better protect older people from abuse should be enacted in Northern Ireland without delay. This should include a criminal charge of corporate neglect to allow for the prosecution of care home or care service owners where abuse and neglect of older people takes place in homes that they own or through services they run.
9. HSC Trusts and older people who self fund their care should be entitled to a refund of part of their fees paid for any time that a care service fails to meet the required standards.

Whistleblowers and protection

10. 'Whistleblowers' and older people or relatives who raise concerns about poor care or abuse should be better supported and better protected from unfair treatment.

Cultural changes in the provision and management of care services

11. A well-trained and registered social care workforce, which is respected, valued and properly remunerated with opportunities for career progression, is essential.
 12. Complaints processes, safeguarding procedures and details of the organisations which can assist complainants should be made clear to all prospective and current service users, their relatives and staff of care services.
 13. The contract through which older people occupy care homes must be reviewed so that as long as the care home can meet their assessed needs, they cannot be evicted without due process, reasonable due cause, and without appropriate alternative care being in place.
- 1.3 The focus of this advice is to propose the need for change in improving inspection processes for care settings, making enforcement actions more rigorous, strengthening protection for whistleblowing and encouraging cultural changes in the provision and management of care services. The issue of what good care looks like is not the subject of this report.

2. Context

- 2.1 The Commissioner for Older People for Northern Ireland (COPNI) has statutory duties to safeguard and promote the interests of older people, to keep under review the adequacy and effectiveness of services provided for older people and to encourage best practice in the treatment of older people.¹
- 2.2 The COPNI corporate plan ‘Hope, Confidence and Certainty’² 2013-15 commits to:
- Examine the current standards required for domiciliary care and compliance with those standards.³
 - Examine the adequacy of the current inspection regime.
 - Determine if any changes are needed to increase protection of older people, and call on Government to address these changes.
- 2.3 A recent Independent Review of “*actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus,*” highlighted the need to look further than domiciliary care and to include nursing and residential care in the Commissioner’s examination. The independent review and a range of individual experiences brought to the Commissioner’s office in casework as well as concerns raised by families to the office has convinced the Commissioner that whilst there are excellent care providers and care workers dedicated to providing high quality care, unfortunately poor quality care is being delivered in certain circumstances to older people in Northern Ireland.
- 2.4 The Regulation and Quality Improvement Authority (RQIA) register and inspect a wide range of health and social care services in Northern Ireland. Their role as an inspector is to “examine all aspects of care provided to assure the comfort and dignity of those using the facilities and ensure public confidence in these services”.⁴ The RQIA’s regulation activity is underpinned by four principles; consistency; targeting; transparency; and accountability.⁵

1 www.legislation.gov.uk/nia/2011/1/contents

2 www.copni.org/images/publications/COPNI_Corporate_Plan_-_Hope_Confidence_Certainty_2013-2015.pdf

3 This was expanded in July 2014 to include the care provided in Nursing and Residential Homes as well as in Domiciliary Care settings.

4 www.rqia.org.uk/what_we_do/index.cfm

5 www.rqia.org.uk/cms_resources/Better%20Regulation%20Inspection%20Principles%20Feb%202013.pdf

- 2.5 England, Wales and Scotland have all experienced a renewed focus on improving regulation, inspection and delivery of care in recent years following identified failings, such as ‘The Mid Staffordshire NHS Foundation Trust Public Inquiry 2013’, reporting on events from 2005-2009⁶. Recent media reports and ongoing concerns raised with COPNI have identified a lack of confidence in the regulated care system in Northern Ireland. This evidence needs to act as the Northern Ireland catalyst for change, before any further independent reviews are needed.
- 2.6 Serious failings in the levels of care provided in nursing, residential and domiciliary settings cannot be allowed to continue.
- 2.7 These proposals for change touch on standards and inspection, enforcement actions needed, protection and support for whistleblowers and the need for a change in the overall culture of promoting care services. They have the potential, if implemented, to improve the levels of care provided, the system of accountability, and ultimately the experiences of older people in care settings by ensuring that these services do not fall significantly below minimum acceptable standards.
- 2.8 These proposals require consideration and action by the Minister for Health, Social Services and Public Safety.

What older people should expect

- 2.9 The minimum standards that apply to residential care homes, domiciliary care agencies and nursing homes are underpinned by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.⁷
- 2.10 The Minimum Standards for Residential Care Homes incorporate 35 standards.⁸ The Minimum Standards for Nursing Homes at present include 40 minimum standards⁹ and the Minimum standards for Domiciliary Care incorporate 16 different standards.¹⁰

6 www.midstaffspublicinquiry.com

7 The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 www.legislation.gov.uk/nisi/2003/431/contents/made

8 DHSSPS, ‘Residential Care Homes: Minimum Standards’, August 2011 - www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

9 A revised document was recently out for consultation until October 2014.

10 DHSSPS, ‘Domiciliary Care Agencies: Minimum Standards’ - www.dhsspsni.gov.uk/domiciliary_care_standards-4.pdf

- 2.11 These ‘standards’ are set out in legislation and underpin the existing structure and quality of care that older people receive.
- 2.12 This report does not aim to define in depth what good care should include at this stage. The subject of what constitutes 'good care' is a significant issue which merits further technical and investigative opinion.
- 2.13 The system of regulation and inspection of care services in Northern Ireland is carried out by the RQIA. This duty is underpinned by legislation however there is no direction within legislation on **how** inspections should be conducted; this is up to the RQIA. The HSC Trusts commission services from care providers and it is then up to the care providers to ensure they are meeting minimum standards of care set out in legislation. Roles and responsibilities can therefore overlap and be fragmented, which leaves a potential gap between the HSC Trusts, care providers and the RQIA. There needs to be a consistent approach taken at all levels.
- 2.14 The Commissioner is aware of a significant lack of confidence in the care system. Examples of excellent care do exist but failings in care continue to happen all too often. The Independent Review of the *“actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus”*, reported at length on the regulated care system failing to be able to ensure good quality care, and of standards of care which were consistently falling below an acceptable minimum standard. It detailed significant failings including the lack of timely enforcement action, a lack of protection and support to whistleblowers, inspection processes lacking a person-centred focus, a lack of protection for individuals, and a poor culture of care.

The Commissioner’s Proposals

- 2.15 Having made initial press comment in August 2014, the Commissioner’s office has since engaged with a wide range of organisations in order to ‘test’ and inform the proposals for change to be made to the Minister of Health, Social Services and Public Safety. These proposals must lead to improvements in the provision of good quality care for older people.
- 2.16 Engagement with experts across the care sector and the wider professional stakeholder group in Northern Ireland, England, Wales and Scotland and a number of older people’s families has further highlighted the need for improvements and support for these proposals.

2.17 The following sections will detail the proposals for the four areas where change is needed:

- Care standards and inspection processes;
- Enforcement;
- Whistleblowing;
- Changes in the culture of care.

2.18 Each section will outline in brief the current situation in Northern Ireland, the Commissioner's proposal and the need for change.

3. Care standards and inspection processes

Proposal 1

3.1 **'The rights, quality of life, dignity and care needs of vulnerable older people should be at the heart of planning, delivering, regulating and inspecting care services; it is their needs that must matter the most'.**

Background

- 3.1.1 Currently in Northern Ireland the minimum standards of care¹¹ underpin planning, delivering, regulating and inspecting care services. These standards form the basis for inspection. The current system of regulation focuses on settings, such as whether it is a care home or domiciliary care service, rather than the rights, needs, hopes and wishes of the person. To ensure good quality care there needs to be an increased focus on outcomes for and satisfaction levels of older people.
- 3.1.2 England, Scotland and Wales are currently modernising and changing their regulation and inspection processes for health and social care services. The changes being implemented in other parts of the UK focus more on the quality of care being provided and the impact that it has on the quality of life, dignity and the fundamental needs of the service users.
- 3.1.3 In Wales a new legislative Bill is expected in 2015 which will reform the regulation and inspection of care and support. The new Bill aims to give people a stronger voice and more control over their care; it proposes a shift to measuring the expectations of, and outcomes for, the individual, rather than just measuring whether or not minimum standards are being met.¹²

11 www.legislation.gov.uk/nisi/2003/431/contents/made

12 wales.gov.uk/topics/health/socialcare/carestandardsact/?lang=en

3.1.4 In England new ‘fundamental standards’ of quality and safety will come into force on 1st April 2015¹³ subject to parliamentary due process and approval. The ‘fundamental standards’ are more focused and clear about the care that people should always expect to receive, and Scotland is in the process of reviewing the national care standards.¹⁴

The need for change

3.1.5 The standards of care should include a set of ‘quality’ indicators for all care services which measure whether service users are being treated with dignity and respect, that they have a good quality of life and are receiving the level of care and support that they need.

3.1.6 Assessing factors which are important to the service user and reflect the ‘lived experience’ of the service would help to provide a more ‘rounded’ assessment of the service provided. Regulation in England and Wales has increased emphasis on analysing the quality of relationships between staff and service users as a key quality indicator. This is an essential cultural change within care settings, moving away from a focus on paperwork for inspections and towards regulators being focused on the fundamental care needs and wishes of the service users.

3.1.7 A wider expansion of standards as they currently exist, to include dignity, respect and humanity, would encourage service providers to meet older people’s needs in a more dignified manner, and would empower older people to make choices about their care and support services.

13 www.gov.uk/government/uploads/system/uploads/attachment_data/file/274719/Regs_draft.pdf

14 hub.careinspectorate.com/knowledge/policy-and-legislation/policy-portals/national-care-standards/

Proposal 2

3.2 **‘Standards for the care of vulnerable older people should be clearly displayed and available to all service users and their families and relatives of all nursing, residential and domiciliary care services as well as for any prospective users’.**

Background

- 3.2.1 Currently in Northern Ireland the minimum care standards set out in legislation are available on the DHSSPS and RQIA websites. However care services are under no obligation to inform service users or relatives of the relevant minimum standards of care. There is a requirement to provide prospective service users with a guide to the services provided but the level and type of information provided is at the discretion of the service provider.¹⁵ This means that the availability of information to service users and relatives varies from setting to setting. For example, some residential care homes may include information about minimum standards in a welcome pack for a resident. In some care homes and domiciliary care services this information is not provided proactively.
- 3.2.2 Information on the minimum care standards should be displayed in an appropriate and accessible way. Displaying information about standards of care on a website will not be accessible to all older people and their relatives, as many may not have access to the internet. As a result, paper based distribution may be more effective and this should be available in alternative formats including Braille, easy read, and languages other than English.
- 3.2.3 The National Standards in Scotland have been cited as a good example of standards that were developed from the point of the view of the people who use the services, and are in ‘easy-read’ format for service users. Two of the minimum standards in Scotland specify that service users must be provided with a breakdown of services and information on the ‘management style’ before they receive the service.¹⁶ Producing standards in Plain English is also important; the current standards in Northern Ireland are contained in long documents drafted in technical language, which would not be clear to anyone unfamiliar with the language of health and social care legislation.

15 Outlined in engagement with COPNI office and RQIA

16 www.scotland.gov.uk/Resource/Doc/924/0013253.pdf

3.2.4 A recent consultation document on draft National Standards for nursing homes and residential care settings providing services to older people in the Republic of Ireland proposes a standard for each resident to have “*access to information, provided in a format appropriate to their communication needs*”. It is stated that one of the features of this is that each resident would be “*provided with an accessible copy of these standards and staff to spend time explaining the standards to each resident, where possible and if the resident so wishes.*”¹⁷

The need for change

- 3.2.5 Older service users and/or their family members need to be able to easily access the care standards for a service they require. This information must be provided in a format that is clear and understandable and should outline what they can expect from the care they are receiving.
- 3.2.6 The standards for inspection are an essential tool in building public confidence in the system of regulated care in Northern Ireland.
- 3.2.7 Current and future service users need to feel reassured that, if the service falls below an acceptable standard of care, they understand what this means, can seek redress, and understand what they can do to improve and challenge poor practice.

17 www.hiqa.ie/consultation-draft-national-standards-residential-care-settings-older-people-ireland

Proposal 3

3.3 'Inspection processes should be rigorous, with decisive and timely enforcement action taken when failings are detected'.

Background

- 3.3.1 The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 established the RQIA as an independent body *“responsible for monitoring and inspecting the quality of Health and Social Care services in Northern Ireland and encouraging improvements”*.¹⁸ This legislation does not however prescribe how this role should be carried out; it is the responsibility of the RQIA to determine the best methodology.
- 3.3.2 In Northern Ireland inspections by the RQIA take place on both an announced and unannounced basis. Each individual care service has a large number of standards to comply with and as a result the RQIA conduct ‘thematic’ inspections. Each year the inspection programme is based around approximately four themes which are informed by the experience of regulating within the sector during the previous twelve months.¹⁹
- 3.3.3 There are some issues with the current inspection process which have been identified by the Independent Review of the *“actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus”* and engagement with concerned friends and relatives of older people receiving care. The issues identified included the large focus on paperwork, meaning inspections can be a ‘tick box’ exercise with little relation to the individuals’ lived experience within a care setting. Excessive paperwork can actually impact negatively on the quality of care provided,²⁰ giving staff less time for personal interactions. Inspection processes need to examine key signs which relate to the ‘quality’ of the individual’s experience within the care setting.

18 www.rqia.org.uk/about_us/index.cfm

19 RQIA, ‘Themes for Inspection Year 2012-2013’ - www.rqia.org.uk/cms_resources/Annual%20Report%20Elements%20and%20Accounts%20Published%20Edition%20Oct%202013.pdf (pg 10 &11)

20 JRF, ‘Is Paperwork in Care Homes Undermining Care for Older People?’ - www.jrf.org.uk/sites/files/jrf/administration-care-homes-full_0.pdf

3.3.4 There is a concern that the thematic style of inspection does not examine compliance with all of the minimum standards on each inspection. The current style of inspection also does not allow for sufficient engagement with older service users and their relatives during inspections. It is imperative that the views of older people and their relatives are captured. It is also recognised that there can be difficulties in ascertaining views of some older service users. For example, some individual older people may not wish or be able to complete a questionnaire or be interviewed. These obstacles could be overcome by using more innovative methods of engagement. One potential method could be offering an advocacy service to help older people or their families to express their views and remain anonymous if they wish.²¹ Soliciting the views of relatives can also be an effective way to fill in gaps in knowledge of the individual older person's experience.

3.3.5 The RQIA since April 2012 have had an engagement officer in place to conduct service user engagement for domiciliary care services to inform the overall quality of services.²² From casework brought to the Commissioner's office and from the Independent Review of the *"actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus"* it is clear that the views of relatives and service users are not always actively sought. At present, time and resources do not place enough emphasis on this important aspect of user/family involvement.

3.3.6 In England all inspections are unannounced. The Care Quality Commission (CQC) has developed a new inspection model which looks at five areas to see if services are:

- safe,
- effective,
- caring,
- responsive to people's needs and
- well-led²³

Reports by the CQC will provide a continuing narrative on each care service inspected to aid understanding of the quality of service provided.

21 Scottish Executive, ;'Standards of Care and Regulation of Care Services in Scotland', <http://docs.scie-socialcareonline.org.uk/fulltext/hcc24full.pdf>

22 www.rqia.org.uk/cms_resources/Annual%20Report%20Elements%20and%20Accounts%20Published%20Edition%20Oct%202013.pdf

23 www.cqc.org.uk/sites/default/files/documents/20131013_cqc_afreshstart_2013_final.pdf

- 3.3.7 The Care Inspectorate Scotland conducts the majority of their inspections on an unannounced basis because they wish to view a service operating as it does on a “normal day”. In 2012-2013 only 4% of inspections were announced.²⁴ Services are inspected against a maximum of four quality themes: quality of care and support, quality of environment, quality of staffing and quality of management and leadership. The Care Inspectorate is aiming to change their inspections as they feel the process is quite disjointed and not ‘quality led’.²⁵ They are currently in the consultation phase of devising new methodology and plan to pilot this in April 2015.²⁶
- 3.3.8 In Wales there are two types of inspection processes; baseline and focused. Baseline inspections occur once every three years and are in depth, covering four quality themes; quality of life, staffing, management and leadership, and quality of the environment. Focused inspections occur twice every three years and can be routine or targeted to address a specific concern.²⁷ They focus on the quality of life of service users and compliance with regulations when poor outcomes are identified. The regulator uses a variety of methods to gather information during inspections, for example the Short Observational Framework for Inspection (SOFI) tool.²⁸ A draft legislative Bill is currently being progressed for the reform of regulation and inspection for care and support and will be introduced to the National Assembly for Wales in early 2015. The new Bill proposes an “*outcomes-based inspection regime, a service based regulation regime and a national institute of care and support*”.²⁹
- 3.3.9 Engagement with relatives and friends of older people receiving care from a registered care home has indicated concerns that even unannounced inspections by the RQIA have some degree of expectation attached. It is suggested that this could be due to early requests for information in relation to inspections, for example, questionnaires or paperwork, which may then prompt suspicions of an impending inspection.

24 Care Inspectorate annual report and accounts 2012-13 -

www.scswis.com/index.php?option=com_docman&task=cat_view&gid=537&Itemid=100182

25 www.careinspectorate.com/index.php?option=com_content&view=article&id=8240&Itemid=709

26 Discussions held with the Chief Executive of the Care Inspectorate Scotland.

27 cssiw.org.uk/docs/cssiw/general/140730baselineinspectionguideen.pdf

28 cssiw.org.uk/docs/cssiw/report/121005sofi.pdf

29 cssiw.org.uk/about/white-paper/?lang=en

3.3.10 To gain an indication of a 'normal day' for a care service the use of unannounced inspections, where there is no prior indication given to the care service in any way, would help to portray the lived experience and identify any early issues that could be 'covered up' if knowledge of an inspection was given. Care services should be inspected at all times; day, night, weekends and bank holidays.

The need for change

3.3.11 Inspection processes must focus on the quality of life of the service users and ensure that their fundamental care needs are met. To deliver more rigorous and rounded inspection processes, inspections need to be longer and seek the views of service users and relatives. More time and resources may be needed to achieve this. Rigorous inspection processes would potentially highlight poor quality care at an earlier stage and could lead to a higher standard of experience and 'lived' care for older people.

3.3.12 Increased numbers of unannounced inspections and wide use of night inspections would help give a fuller indication of the day to day life of the care service and also aim to identify any compliance issues.

3.3.13 For an inspection to be truly informative about the lived experience of older service users, the views of older service users and their relatives need to be drawn out as part of the inspection process, and need to inform the results of the inspection.

Proposal 4

- 3.4 'The regulation and inspection service should include a rating system for care homes and domiciliary services. In addition to an overall rating, it should clearly identify if there are any breaches of regulations or failures to comply with improvements required.'**

Background

- 3.4.1 At present Northern Ireland does not have a rating system for residential and nursing care homes or for domiciliary services. A rating system would help provide an accessible system for individuals, encourage continuous improvement and would increase transparency. The RQIA has indicated possible consideration of the merits of introducing an overall rating for quality as part of a planned review of inspection methodology currently being undertaken.
- 3.4.2 The Care Quality Commission in England rate the quality of care provided by services using a four point rating scale:
- Outstanding;
 - Good;
 - Requires Improvement;
 - Inadequate.
- 3.4.3 This rating scheme is believed to be important for both the sector and the people who use the services. The frequency of inspections will depend on the rating but inspections will continue to be triggered by concerns, and there may also be random inspections of a number of good or outstanding services.³⁰ The Care Inspectorate Scotland also rate care services by awarding a grade on a six point scale ranging from 'Unsatisfactory' to 'Excellent'.³¹

30 www.cqc.org.uk/sites/default/files/documents/20131013_cqc_afreshstart_2013_final.pdf

31 www.scswis.com/index.php?option=com_content&view=article&id=8140&Itemid=750

3.4.4 The CQC confirmed to the Commissioner's office that when a ratings system was introduced, the percentage of homes that were rated as 'poor' decreased dramatically. From 22% of homes being rated as poor, this decreased to 15% six months after the introduction of a ratings system and decreased further to 9% one year after.

3.4.5 A viable rating system can be based either on compliance and regulation together or based on user satisfaction and applying this in order to generate a rating. While both factors are important parts of a robust and comprehensive rating system, particular emphasis should be placed on exploring user satisfaction. Ratings systems can add a clear representation of the lived experience of an older person using a care service, which is easily accessible and clear.

The need for change

3.4.6 The introduction of a rating system would help to provide an indication of the standard of care delivered by a service for service users, relatives and these commissioning services. This would assist service users or relatives without the need to read and interpret lengthy inspection reports. Older people and their families should not have to do this in order to make difficult decisions on the selection of care services, often at a point of crisis. Instead, this type of system could offer an accessible overall rating and a qualitative description indicating the standard of care available. Inspection reports should continue to be publicly available and easily accessible.

3.4.7 A rating system would allow service users and relatives to compare and contrast when choosing the service that they believe would best suit their needs. It is also expected that a rating system would encourage providers to increase standards and therefore continuously strive to provide the best quality care.

4. Enforcement

Proposal 5

4.1 'There should be clear and rigorously applied sanctions taken against care providers for non-compliance with the minimum standards.'

Background

- 4.1.1 The Independent Review of the *“actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus”*, concluded that there were opportunities for the RQIA to take a more rigorous approach to the enforcement of regulations and minimum care standards, expressing the view that the RQIA had made “limited use” of enforcement powers.
- 4.1.2 The RQIA should use strong sanctions against care providers when ‘softer’ improvement measures are not working to ensure compliance with the minimum standards. At present the RQIA possess many of these powers³² but are making limited use of them. During 2012-2013, the RQIA took 34 enforcement actions against residential care homes, nursing homes and domiciliary care agencies. During this time 14,785 incident notifications were received by RQIA.³³
- 4.1.3 At present, when non-compliance is identified following an inspection, an ‘improvement notice’ is issued. This is a non binding recommendation, which details the non compliance and an improvement plan (including actions to be taken within a specified timeframe). If non compliance continues, the RQIA can issue a ‘failure to comply’ notice to the service provider. This is a requirement,

32 RQIA, ‘RQIA Enforcement Procedures’,
www.rqia.org.uk/cms_resources/Enforcement%20Final%20Published%20Document_%20RQIA%20Enforcement%20Procedures____.pdf

33 www.rqia.org.uk/cms_resources/Annual%20Report%20Elements%20and%20Accounts%20Published%20Edition%20Oct%202013.pdf

It is recognised that not all incident notifications would lead to enforcement actions; the specific statistics were not available so these should be interpreted with caution.

meaning it is binding and the service provider will be breaking the law if they do not comply within a timeframe of no longer than 90 days. This three month period in which the service provider has to comply is too lengthy when an identified failure has already persisted. More stringent action should be taken when consistent failure has been identified, including a shorter period in which the service provider must comply.

- 4.1.4 In England, the CQC also has similar enforcement powers but in particular it can serve a 'penalty notice' in a number of circumstances; when there is a failure to be registered, the registered person has failed to comply with certain requirements of the Act or regulation and where the offence is continuing when the timescale in a warning notice has expired. The fines range from £300-£50,000 depending on the offence.³⁴
- 4.1.5 In Wales, a service that remains non compliant following a non compliance notice, or is deemed to be a service of concern, will be designated as an 'escalating concern' or 'service of concern'. This will define extended timeframes for compliance before further escalation. Where a 'service of concern' remains non-compliant for a period of more than 12 months, "active consideration" will be given to cancelling the service's registration.³⁵

The need for change

- 4.1.6 When care providers do not comply with minimum standards on a continual basis, there should be clear sanctions which are rigorously applied. These sanctions need to be progressed decisively and swiftly by the RQIA without undue delays. A 'special measures' regime may be useful alongside clear improvement plans over a tight timeframe, but must also be backed by the threat of immediate closure.³⁶
- 4.1.7 Sanctions should place a significant penalty on the care provider and act as a robust incentive towards compliance for the provider. Strict sanctions and financial penalties are a useful deterrent against poor practice and will assist to ensure compliance in a timely manner.

34 www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf

35 CSSIW, 'Responding to Non Compliance, Guidance for Regulatory Inspectors: Non Compliance and Enforcement Process' - cssiw.org.uk/docs/cssiw/general/140121noncomplianceguideen.pdf

36 A special measures regime is a collective term for a new system tackling poor care that designates a home or service failing older people.

4.1.8 Engagement has shown that relatives of older people who have experienced consistent failures by a care service believe that there should be consideration of placing specialist management teams into failing services to 'turn them around' and improve the service, such as the approach taken in schools and prisons. This has been done previously in 2013 when the DHSSPS commissioned a small turnaround and support team to address the significant challenge and seek to improve performance within the Northern HSC Trust.³⁷

Proposal 6

- 4.2 ‘Persistent or serious breaches of regulation and/or compliance should result in decisive sanctions being applied without delay and within a defined timeframe. The sanctions that should be applied should include de-registration of owners and managers, home closure, financial penalties as well as suspension of new admissions to care homes, and domiciliary care services.’**

Background

- 4.2.1 In Northern Ireland, the RQIA has the power to introduce formal notices of ‘failure to comply’ with a stated timeframe of less than 90 days to comply. The RQIA can also cancel, refuse, vary and remove or impose conditions on registration according to the performance of a service. When a ‘Notice of Decision’ is given the provider can make an appeal to the Care Tribunal within 28 days³⁸. The RQIA has recourse to an urgent procedure for cancelling a registration or to vary, remove or impose a condition on it, when other actions have failed to ensure compliance.
- 4.2.2 Despite these formal powers, the Independent Review of the *“actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus”* and notifications to the COPNI office show instances of sanctions either not being applied robustly enough or not applied at all. This allowed unacceptable standards of care to continue being provided. The recent Independent Review of the *“actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus”* detailed numerous breaches of standards that were not enforced by rigorous sanctions.³⁹

38 The Care Tribunal was set up under the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003. It is set up to hear appeals against decisions in relation to the RQIA relating to the regulation of residential care homes, nursing homes and independent health care providers, for example. www.courtsni.gov.uk/en-GB/Tribunals/CareTribunal/Pages/default.aspx

39 RQIA, ‘Independent Review of the Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House, Carrickfergus’, July 2014, pp.46-73, pp.83-117 - www.rqia.org.uk/cms_resources/Independent%20Review%20of%20Cherry%20Tree%20House,%20Carrickfergus.pdf

- 4.2.3 The sanction processes in England and Scotland are similar to Northern Ireland in terms of the processes involved. When non-compliance is first identified, there is an action plan and timeframe to allow an opportunity for improvement. Then, depending on compliance and remaining risk, the regulator can increase the enforcement action. The CQC believe that penalty notices, as described in the previous section, are a way of achieving compliance without beginning lengthy and costly proceedings as a realistic alternative to prosecution.⁴⁰
- 4.2.4 However there is a difference in the application of enforcement actions across England, Scotland and Wales. When non-compliance continues or there is repeated non-compliance, the CQC investigates the impact that the issue would have on service users. Enforcement actions can include a compliance action and/or a warning notice and civil and/or criminal action.
- 4.2.5 Where a registered person demonstrates 'low level' but continuous or frequent failure to comply with legal requirements, the CQC will usually escalate enforcement action so that problems are dealt with swiftly and firmly⁴¹. The timeframes for action by the CQC are not stated as they are expected to vary on a case by case basis; it would depend on the inspector's individual judgment of the seriousness of the non-compliance.
- 4.2.6 The Care Inspectorate in Scotland has the power to make 'proposals to cancel' notices in response to meeting the timescale for improvement. These improvement notices are issued in response to breaches of regulation or conditions. They include an order to comply, a timescale to do this in, and details of how compliance can be achieved. The Care Inspectorate can also institute an 'Emergency Condition Notice', if they believe there is a serious risk to the life, health or wellbeing of people and it can take effect immediately. An 'Emergency Cancellation of Registration' can be granted by a Sheriff Court to force the provider to close if the service is placing a person's life, health or wellbeing at serious risk.⁴²

40 www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf

41 www.cqc.org.uk/sites/default/files/documents/enforcement_policy_june_2013.pdf

42 Social Care and Social Work Improvement Scotland, 'Enforcement Policy' - Enforcement Policy Publication Code: OPS-0511-037

The need for change

- 4.2.7 Where persistent or serious breaches in regulation are found, decisive sanctions should be applied immediately and actioned over a prompt and clearly defined timeframe to map the road to compliance. Sanctions being applied without delay and within a defined timeframe would act as an incentive for the required standards to be met by the owners and management of care settings.

Proposal 7

4.3 'Health and Social Care Trusts should not continue to place vulnerable older people in nursing and residential care homes, or with domiciliary care services, where there are serious unresolved compliance failures and unacceptable standards of care'.

Background

- 4.3.1 HSC Trusts can decide which nursing and residential care homes or domiciliary care services to use for older people at their discretion. In Northern Ireland HSC Trusts have continued to place older people in need of care services into settings where there has been unresolved compliance failures and unacceptable standards of care. The Independent Review of the *"actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus"* identified that the Northern HSC Trust relied on Cherry Tree House management to provide assurance regarding the quality of care, and continued to place residents in the home.⁴³
- 4.3.2 In Scotland, England and Wales, local authorities halting placement of older people in services that are not meeting minimum standards is a regular feature of their sanction systems.
- 4.3.3 In Scotland the local authorities can consider non-compliance as a breach of contract and restrict admissions. Engagement with the regulator in Scotland emphasised that restriction on new admissions is the most frequently used sanction.
- 4.3.4 In England the commissioners of care services, such as the local authorities, can investigate the quality of the services that they provide and if there is evidence of unresolved problems they can restrict new admissions from entering a care home which is failing to perform.⁴⁴ There are examples across many councils of this power being used. For example in 2013-2014, Brighton and Hove City Council suspended

43 'Independent Review of the Actions Taken in Relation to Concerns raised About the Care Delivered at Cherry Tree House', pp.11-12
www.rqia.org.uk/cms_resources/Independent%20Review%20of%20Cherry%20Tree%20House,%20Carrickfergus.pdf

44 www.gov.uk/government/uploads/system/uploads/attachment_data/file/250078/bis-13-1245-focus-on-enforcement-review-of-adult-care-homes-sector.pdf

admissions to five separate care homes, with the shortest suspension lasting nine days, and the longest suspension being over 200 days and ongoing.⁴⁵

4.3.5 In Wales, the local authorities or local health boards (LHB's), subject to the terms of the contract, can apply to place an embargo on a particular home i.e. choose not to place new service users there for a specified reason.⁴⁶ There must be a clearly evidenced rationale for embargos, and applications for an embargo would be open to challenges through judicial review. Placing an embargo on placement could ultimately lead to the closure of a home.

The need for change

4.3.6 HSC Trusts need to be kept aware of unresolved compliance failures and unacceptable standards of care, and be ready to take swift and decisive action to protect the safety and wellbeing of older people.

4.3.7 A restriction on new admissions would also have a financial impact on the care service provider, giving them an incentive to provide high quality care and to comply with minimum standards. This deterrent would help to improve the condition of the care services more quickly.

45 Care Homes/Suspension of admissions, Freedom of Information Request, foi.brighton-hove.gov.uk/requests/3117

46 cssiw.org.uk/docs/cssiw/general/140429noncomplianceen.pdf

Proposal 8

- 4.4 'New legislation to better protect older people from abuse should be enacted in Northern Ireland without delay. This should include a criminal charge of 'corporate neglect' to allow prosecution of care home and care service owners who abuse and neglect older people in homes they own or services they run'.**

Background

- 4.4.1 The COPNI report *'Protecting our Older People in Northern Ireland: A Call for Adult Safeguarding Legislation'*⁴⁷ called for new legislation to safeguard adults at risk of harm or abuse in Northern Ireland. This report calls on the Ministers of Justice and Health, Social Services and Public Safety to consider the introduction of a criminal charge of 'corporate neglect'.
- 4.4.2 In the case of abuse against an older person, in addition to penalties against individual social care workers, responsibility should also lie with the employer. A charge of corporate neglect would mean that responsibility for the incident would rest with the employer.
- 4.4.3 As there is currently no requirement for all care workers to be registered with the NISCC, the charge of Corporate Neglect would strengthen powers individuals have to bring charges of Corporate Neglect. For most workers registration is mandatory but it is still optional at this point for the domiciliary care workforce.⁴⁸ This should change and all social care workers should be registered.
- 4.4.4 Legislation exists for the prosecution of corporate bodies under a charge of corporate manslaughter. However, this would not cover circumstances of poor quality care which leads to abuse or neglect of an older person.

47 www.copni.org/images/publications/Protecting_Our_Older_People_in_Northern_Ireland_Report_1.pdf

48 A consultation document on the introduction of compulsory registration for social care workers with the Northern Ireland Social Care Council, 2009 detailed a proposed introduction date for July 2013. However discussions with DHSSPS have revealed that this has not yet been implemented.

- 4.4.5 In England evidence of the use of a power of ‘corporate neglect’ is quite sparse, despite the provision for a civil charge of ‘corporate neglect’ under Section 30 of the Care Standards Act 2000 and Section 91 of the Health and Social Care Act 2008. But as a regulator the CQC’s powers of enforcement are limited to the “*manager of a home*”, not the corporation itself, and the CQC does not bring cases under the civil charge of ‘corporate neglect’.
- 4.4.6 There have been calls for the introduction of a criminal charge of ‘corporate neglect’ in England, and at present the government is reviewing responses to a consultation on introducing new offences of ill treatment or willful neglect.⁴⁹
- 4.4.7 The situation is similar in Scotland where there is the option to bring a civil charge of ‘corporate neglect’, but there are no current plans to introduce this charge.

The need for change

- 4.4.8 Registered owners must be held responsible for cases of neglect or abuse against older people which take place in the homes or services they run.
- 4.4.9 A criminal charge of corporate neglect would help to encourage higher standards of care and better reporting of alleged abuse across care services. Care providers could then be made liable for the actions of their staff and this could in turn encourage highlighting by staff of issues in order to help improve the quality of care provided in these settings as well as encouraging better reporting.

49 Paul Burstow (Ed.), ‘Care and Corporate Neglect: Corporate Accountability and Adult Safeguarding’, 2013

Proposal 9

4.5 'Health and Social Care Trusts and older people who self fund their care should be entitled to a refund of part of their fees paid for any time that a care service fails to meet the required standards'.

Background

- 4.5.1 At present there are two groups of older people in Northern Ireland who do not have enough financial protection when a care service fails to meet the required standards. Although older people who are placed in care services by the HSC Trusts are protected by a regional contract between the Trust and care service provider, this does not entitle them to a refund if a care service fails to meet required standards.
- 4.5.2 Self funders will rely on terms specified in an individual contract from the service provider, which may vary from the regional contract between HSC Trusts and care service providers, meaning that there are varied levels of protection available.
- 4.5.3 Neither group is entitled to a refund if the care service fails to meet the required standards.
- 4.5.4 A facility to obtain refunds would be consistent with the contract law principle of reasonable expectations of a contract being fulfilled. If the contract is not being fulfilled, there should be a reasonable expectation of compensation and the contract being amended or cancelled.

The need for change

- 4.5.5 Older people who self fund and HSC Trusts who pay for care should have recourse to a procedure that would entitle them to a refund on part of their fees paid when a service has been found to not meet minimum standards.
- 4.5.6 This would give older people recourse to proper compensation when standards are not being met, and act as a further incentive for service owners and managers to ensure that they meet minimum standards and provide good quality care.

5. Whistleblowers and protection

Proposal 10

5.1 'Whistleblowers and older people or relatives who raise concerns about poor care or abuse should be better supported and better protected from unfair treatment.'

Background

- 5.1.1 The Independent Review of the “*actions taken in relation to concerns raised about the care delivered at Cherry Tree House*” emphasises that “risk within an organisation is often recognised by people who work in, or with that organisation.”⁵⁰ The main whistleblower at Cherry Tree House did not feel supported by other organisations and felt intimidated, as well as finding it difficult to understand the roles and responsibilities of the different organisations in the Health and Social Care structure. The whistleblower also felt bullied within the workplace, and did not feel sufficiently updated on progress when complaints were made.⁵¹
- 5.1.2 The Public Interest Disclosure (Northern Ireland) Order 1998 provides a remedy for workers if they suffer workplace reprisals for raising genuine concerns.⁵² The RQIA Whistleblowing policy states that concerns should initially be dealt with by the employer. If management does not act appropriately or the worker does not feel confident doing this they can instead make a disclosure to a ‘prescribed body’ as set out in legislation⁵³. This includes a regulator such as the RQIA and the Northern Ireland Social Care Council (NISCC).⁵⁴

50 ‘Independent Review of the “Actions Taken in Relation to Concerns Raised about the Care Delivered at Cherry Tree House, Carrickfergus”, p.43 - www.rqia.org.uk/cms_resources/Independent%20Review%20of%20Cherry%20Tree%20House,%20Carrickfergus.pdf

51 Outlined in engagement with COPNI office

52 www.legislation.gov.uk/nisi/1998/1763/contents/made

53 www.legislation.gov.uk/nisr/2012/283/made

54 www.rqia.org.uk/cms_resources/Guidance%20for%20whistleblowers_09102013.pdf

Depending on the details, the RQIA may do one or more of the following: an announced inspection; escalation; raising the matter with the service provider; contacting the DHSSPS, HSC Board or relevant Trust to decide on appropriate action or notifying another public body to lead an investigation of the concern. Additional guidance was issued in March 2012 by the Minister for Health, Social Services and Public Safety, Edwin Poots MLA, emphasising support for protection of whistleblowers.⁵⁵

- 5.1.3 In England the CQC are looking at ways to improve the support they provide to whistleblowers.⁵⁶ After engagement with whistleblowers from across health and social care, they are commissioning an external review to look at their current systems for responding effectively to staff who approach them with concerns.⁵⁷
- 5.1.4 The Care Inspectorate Scotland's Whistleblowing policy states that concerns should be directed to them or to the Scottish Social Services Council; directly with their employer or to a professional body such as the RCN if coming from nurses in a nursing home. Engagement with the regulator in Scotland indicated that whistleblowing does not happen often in Scotland, as many individuals use the complaints system.
- 5.1.5 The Welsh Government also aims to ensure the Public Interest Disclosure Act 1998 is adhered to through the Raising Concerns (Whistleblowing) Policy⁵⁸ and are reviewing concerns (complaints) handling within NHS Wales.⁵⁹
- 5.1.6 A number of high-profile scandals across the UK, and the need for a number of independent reviews before the real issues are reported, have highlighted a reluctance of some individuals to disclose concerns about poor practice or abuse within the workplace.⁶⁰ It is clear that whistleblowing legislation does not provide 'adequate protection' to people disclosing their concerns.⁶¹

55 www.rqia.org.uk/cms_resources/Whistleblowing%20Letter%20Minister%20Poots.pdf

56 Kim Holt, 'My Work with CQC', <http://www.cqc.org.uk/content/kim-holt-my-work-cqc>

57 www.cqc.org.uk/content/conversation-whistleblowers

58 www.wales.nhs.uk/governance-emanual/document/219399

59 wales.gov.uk/about/cabinet/cabinetstatements/2014/nhscomplaints/?lang=en

60 van den Hende, R. (2001) Supporting Public interest Whistleblowing *Journal of Adult Protection*, 3(3), pp.41-44

61 Lewis, D. (2008), Ten Years of Public Interest Disclosure Legislation in the UK: Are Whistleblowers Adequately Protected *Journal of Business Ethics* Volume 82 (2) pp. 497-507

The need for change

- 5.1.7 Whistleblowers need to be protected by the law to make genuine disclosures and should be supported to do so. In many cases, poor care was only brought to the attention of those responsible because of the actions of the whistleblower. A dedicated response to whistleblowers is essential and should be adequately resourced.
- 5.1.8 There should also be separate, additional support from an independent and external provider for whistleblowers.
- 5.1.9 While it is good practice to have information regarding whistleblowing displayed, it is important that staff are actively encouraged to whistleblow in the interests of the vulnerable older people they care for.
- 5.1.10 An independent body to support whistleblowers throughout the process would better support individuals, alongside whistleblowing processes to the regulator or their employer. A culture of voicing concerns alongside effective support systems for those who do, would improve the experience of those who are brave enough to make a genuine report. Adequate support will help, but there needs to be a change in culture that makes whistleblowers more likely to speak out, to embed effective and fair whistleblowing.

6. A cultural change in care

Proposal 11

6.1 'A well-trained and registered social care workforce, which is respected, valued and properly remunerated with opportunities for career progression, is essential'.

Background

6.1.1 The Commissioner's engagement revealed a number of issues which relate to the social care workforce; these include registration, levels of staffing and the ability of management in 'failing' services to subsequently move and work in another service.

Recruitment

6.1.2 Currently in Northern Ireland all social care workers must have an Access NI check before beginning employment. There are different levels of checks which can be conducted but when working with vulnerable adults an 'enhanced disclosure' form is required. This involves a criminal record check by Access NI and a check against the Disclosure and Barring Service's 'barred list' of individuals who are not permitted to work with vulnerable individuals. By law, employers must check an individual's criminal history before they recruit someone who will be working with vulnerable adults.⁶²

6.1.3 There is evidence, from casework to the Commissioner's office and engagement with families of older people, of 'failing' managers being able to move around the care sector. 'Failing' registered managers who are not held to account by their employer can leave before disciplinary action or investigation occurs, and can then move around the system. There is a problem of management being able to continue employment in the care sector by taking up post in another service.

62 www.nidirect.gov.uk/index/information-and-services/employment/employment-terms-and-conditions/starting-a-new-job/accessni-criminal-record-checks/about-accessni.htm

6.1.4 There should be a rigorous system to check the history and references of all individuals who work with vulnerable adults. Access NI disclosure forms already go some way to assuring the background of individuals but there needs to be adequate checks to all previous employers to ensure that individuals cannot move from a service providing poor care to manage another care service, putting vulnerable older people's lives at risk.

Registration, training and pay

6.1.5 Currently in Northern Ireland there is no requirement for the entire social care workforce to be registered with the Northern Ireland Social Care Council (NISCC).⁶³ For domiciliary care workers registration is not mandatory but optional at this point.⁶⁴

6.1.6 Registration helps to ensure that social care workers are trained appropriately and are accountable for the standard of care provided. This is crucial, to emphasise the value of this important role and it also allows people to be taken off the register if poor practice had been identified.

6.1.7 Motivation and retention levels within the care workforce have been highlighted as an issue, especially for those low paid roles which require "physically and emotionally exhausting work"⁶⁵, meaning that staff turnover is high in this sector. Improvements in pay and training could improve staff satisfaction, potentially reducing high turnover, as well as increasing skills to do the jobs effectively.⁶⁶

Staffing levels

6.1.8 Another staff related issue which has been brought to the Commissioner's attention through case work and engagement with stakeholders is staffing levels.

63 Discussions held with the Northern Ireland Social Care Council

64 A consultation document on the introduction of compulsory registration for social care workers with the Northern Ireland Social Care Council, 2009 detailed a proposed introduction date for July 2013. However discussions with DHSSPS have revealed that this has not yet been implemented.

65 JRF, 'My Home Life: Promoting quality of life in care homes'
www.jrf.org.uk/publications/my-home-life

66 JRF, 'Is Paperwork in Care Homes Undermining Care for Older People?' -
www.jrf.org.uk/publications/excessive-paperwork-care-homes-undermining-care-older-people

There are staffing level guidelines supplied by RQIA for nursing⁶⁷ and residential care services⁶⁸, which lay down minimum staffing ‘hours’ against the number of residents, and their dependency levels, to apply during the day and the night. However the status of this as ‘guidance’ does not require or compel service providers to ensure specific level of staff.

- 6.1.9 There is a concern that the minimum staffing levels currently outlined in guidance are already quite low. The minimum standards for residential and nursing care in relation to staffing states it is necessary that *“at all times the staff on duty meets the assessed care, social and recreational needs of residents”*. However it would appear the same advice does not cover domiciliary care services.
- 6.1.10 Research has indicated that staffing levels can have an impact on the quality of care provided.⁶⁹ Low staffing levels can also mean there is limited time available for engagement with older service users.
- 6.1.11 There have been a number of instances highlighted both within the Independent Review of the *“actions taken in response to concerns raised about the care delivered at Cherry Tree House Carrickfergus”* and through approaches to the COPNI office of minimum staffing levels not being adhered to and an apparent lack of enforcement. A report by the Human Rights Commission highlighted how poor staffing levels can sometimes mean residents wait an unacceptable amount of time for assistance.⁷⁰

Management

- 6.1.12 Management play an important part in the delivery of care, it is essential that managers have excellent leadership skills to encourage and lead staff to provide the best possible care and strengthen communication between care services, service users and their friends and relatives.

67 RQIA, ‘Staffing Guidance for Nursing Homes’, June 2009, www.rqia.org.uk/cms_resources/Staffing%20Guidelines%20for%20Nursing%20Home%20Version.pdf

68 RQIA, ‘Staffing Guidance for Residential Homes’, June 2009, www.rqia.org.uk/cms_resources/Staffing%20Guidelines%20for%20Residential%20Care%20Homes.pdf

69 Kane R, Shamiyan, Mueller C, Duval S and Wilt T (2007) The Association of Registered Nurse Staffing Levels and Patient Outcomes: systematic review and meta analysis, *Medical Care*, 45(12), pp. 1195-1204.

70 Northern Ireland Human Rights Commission, ‘In Defence of Dignity: The Human Rights of Older People in Nursing Homes’, www.nihrc.org/documents/research-and-investigations/older-people/in-defence-of-dignity-investigation-report-March-2012.pdf

- 6.1.13 The CQC since using their new inspection methodology have found that good leadership drives up quality and safety overall. In more than 80% of cases that they have inspected so far the rating for 'well-led' was the same as the overall quality rating. The CQC believe that 'well led' organisations have strong and effective leadership, an open and supportive, values-driven culture and stable management.
- 6.1.14 Management should support staff in their registration, training and ongoing development. As mentioned previously, it is essential that rigorous background checks are conducted on all social care staff and, with evidence of 'failing' registered managers being able to move around the care system, it is crucial that managers receive the same in-depth disclosures when beginning employment in a new setting.

The Need for Change

- 6.1.15 All levels of staff in the social care workforce should be registered with the appropriate body and be required to undertake ongoing training and continuous professional development. Pay levels should match the status and responsibilities of the job. The role of a carer should be respected, valued and properly remunerated. The social care workforce should be valued and rewarded appropriately for possessing the essential skills and competencies needed to provide good quality care to older people.
- 6.1.16 Increased staff levels would enable more of their time and energy to be devoted to engaging with individuals. This may be achieved by introducing increased normative staffing levels or legislation underpinning minimum staffing levels.
- 6.1.17 Staff/service user ratios should allow staff to provide a high level of care that goes beyond fulfilling minimum objectives or urgent requirements. This would also minimise the risk of unacceptable incidents occurring where older people have been left alone for large amounts of time while requesting or needing urgent attention, or where there are no staff visible. This will lead to improved, more individualised care for the older person as their requirements and preferences are expressed and understood more clearly.
- 6.1.18 The current lack of continuity in registration, levels of staffing and management in failing services not being held to account diminishes the quality of life and dignity of service users. There needs to be a good culture of care in all settings with well motivated and led social care staff who are registered, receive essential training, are properly remunerated and valued.

Proposal 12

6.2 'Complaints processes, safeguarding procedures and details of the organisations which can assist complainants should be made clear to all prospective and current service users, their relatives and staff of care services'.

Background

- 6.2.1 Casework received by the Commissioner's office has shown that older people are often unsure where to go when they wish to raise a complaint. This was an issue that was also identified in the Independent Review of the *"actions taken in relation to concerns raised about the care delivered at Cherry Tree House Carrickfergus"*. The review outlined that families were particularly critical of Cherry Tree House's management of complaints, and were not clear about the roles and responsibilities of the different health and social care organisations in handling complaints, or the methods or support available to complainants. Staff who raised complaints felt that they received little support from Cherry Tree House or external organisations. Engagement with key stakeholders has indicated that older people or their families can often be reluctant to make complaints for fear of adverse treatment.
- 6.2.2 The situation is not helped by a lack of clarity about who is responsible for complaints handling in Northern Ireland, with there being no single official independent body that people are explicitly directed to for help and assistance in making a complaint. There have been instances shared with the Commissioner's office through casework and also evidenced in the Independent Review of the *"actions taken in response to concerns raised about the care delivered at Cherry Tree House Carrickfergus"* of services or HSC Trusts (as service purchasers) investigating themselves. This is not an adequate process and does not appear to ensure full independent investigation of complaints.
- 6.2.3 Older service users and their relatives need to have confidence that the complaints process is independent from the providers of the service. The process needs to be independent and clearly seen as independent by those who may need to rely upon it.
- 6.2.4 The registered person should openly and regularly seek reviews of the quality of service provision provided and ensure that all complaints are taken seriously and dealt with promptly and effectively.

6.2.5 The Care Inspectorate Scotland has a legal duty to investigate complaints and has a single helpline that everyone with a complaint can phone. This is a single clear and accessible point through which complainants can access the system. They conduct full investigations on behalf of many of these complaints, working through specialist complaint teams.

6.2.6 It is clear from engagement and casework undertaken that often relatives have a fear of making a complaint, because they are worried about a complaint having a negative impact on their relative receiving a care service.

Need for change

6.2.7 All service users, prospective service users, relatives and staff should have access to details for complaints processes and safeguarding procedures, and the details of organisations that can help them. The language used in these communications should be clear so that older people and staff understand how they can be protected, and what their responsibilities are. This will make it easier for older service users, staff and relatives to raise important complaints, because they will know who to go to. A clear perception of the structure and independence of the complaints process means service users, staff and relatives would be more confident of making complaints.

6.2.8 A change in the culture of seeking, receiving and processing complaints is needed. Complaints need to be actively sought more regularly. When complaints are made they should be openly received and dealt with fairly. Engagement with older people and their families has also highlighted the opinion of developing a separate branch of the RQIA to be an independent investigative authority.

6.2.9 All complaints should be thoroughly, promptly, proportionately and independently investigated. There must be clear, concise follow ups, sanctions where appropriate and future checks to ensure ongoing compliance.

Proposal 13

6.3 **‘The contract through which older people occupy care homes should be reviewed so that as long as the care home can meet their assessed needs, they cannot have their tenancy terminated without due process, reasonable due cause, and without appropriate alternative care being in place.’**

Background

- 6.3.1 Older people should know and understand, as much as possible, what to expect from the care setting that they are living in. It has been identified through casework received by the Commissioner’s office that issues arise in care settings but that these can be managed through the contract between a provider and service user. This sometimes results in the residents of care homes being asked to leave at short notice.
- 6.3.2 Currently in Northern Ireland, in relation to care homes, residents have a license to occupy. This license provides less legal protection than a tenancy or a lease would, especially in relation to eviction.
- 6.3.3 Casework highlighted to the Commissioner’s office and the Independent Review of the *“actions taken in relation to concerns raised about the care delivered at Cherry Tree House Carrickfergus”* demonstrate an example of transferring an individual to another home following a family complaint of neglect.⁷¹ Contacts to the Commissioner’s office also indicate that families frequently do not wish to make a formal complaint because of fear of reprisals against the resident.
- 6.3.4 At present the Minimum Standards for Nursing Homes stipulate that *“each patient has an individual written agreement setting out the terms of residency regarding the services and facilities to be provided.”* The individual service user agreement that an older person enters into usually specifies that the care provider can issue a resident with ‘reasonable’ notice that they must leave the home within a stipulated time period.⁷²

71 Independent Review of the Actions Taken in Relation to Concerns Raised About the Care Delivered at Cherry Tree House’, p.18 - www.rqia.org.uk/cms_resources/Independent%20Review%20of%20Cherry%20Tree%20House,%20Carrickfergus.pdf

72 Under Regulation 33 of the Nursing Home regulations

6.3.5 The regional residential and nursing home specification and contract between the Trusts and individual care homes contains details of referral, admission, transfer and discharge arrangements. The contract allows a home in certain situations to terminate a placement giving the Trust 24 hours notice.⁷³

The need for change

- 6.3.6 The contract between a provider and service user must be strengthened to give increased legal protection for the older person in receipt of care. The contractual arrangements whereby older people occupy care homes must be reconsidered or reviewed in order for proper protection and greater security of occupancy to be provided. There must be an exact definition of what circumstances would represent “reasonable due cause” to be able to serve a termination of tenancy notice to a resident. In particular alterations must be made to ensure that people cannot be removed, from what is their home, unreasonably.
- 6.3.7 There should be stronger access to advocacy and support as part of this process, in instances where there is the possibility of an older person being moved from the home they are resident in. Advocacy and support would mean that the process would be fairer, with the older service user given a fair and transparent opportunity to have their views heard as part of the decision making process.
- 6.3.8 Where an individual has to seek alternative accommodation there should be an agreed process in place to identify a service to meet their needs with an agreed timeframe for this to take place, perhaps alongside support for the older person during the transition, informed by the older person’s choices and preferences where possible.
- 6.3.9 A more robust contract of tenancy would mean older people would have better protection from unfair upheaval, and would mitigate against providers being able to ‘move residents out’ or stating that they could no longer meet their needs in the event that the resident or family had a complaint about the service or treatment. If they had to be moved, it would also specify a minimum timeframe for the individual to receive an alternative service to meet their needs, ensuring minimal distress from the transition as far as possible.

73 ‘Regional Residential and Nursing Home Specification and Contract’ - www.northerntrust.hscni.net/pdf/Regional_ResidentialNursing_Home_Specification_and_Contract.pdf

7. Conclusion

- 7.1 All care for older people should be of the highest standard with the needs, wishes and experiences of older people the most important feature.
- 7.2 Older people should have every expectation that care services are inspected rigorously and that the inspection process will examine what is most important to older people. They should expect sanctions to be applied decisively, and in a reasonable timeframe against services that do not provide them with an acceptable standard of care.
- 7.3 Older people should expect that if they (or their relatives, or staff) raise concerns about poor care, that they should be heard and be appropriately supported and protected. They should also expect to live in an environment where the culture values older people, and focuses on sustaining their quality of life. These proposals should help expedite improvements in all of these areas.
- 7.4 Regulation and inspection alone will not ensure good quality of care. The regulation and inspection process needs to include clear pathways to improving the quality of life and experience of an individual older person, which should be fundamental. New measures need to be accompanied by a change in the culture of care, to one that is more person centered and fosters stronger relationships between those who are being cared for and those who are caring.
- 7.5 The Commissioner expects that the proposals contained in this report will be fully considered by the Minister for Health, Social Services and Public Safety and the resulting actions taken be communicated clearly. If fully implemented, these proposals would lead to better care and protection being given to older people in care settings across Northern Ireland.

SUMMARY: Recommendations from the Independent Review and The Commissioner's Advice for a 'whole-system' change

Independent Review of the actions taken in relation to the concerns raised about the care delivered at Cherry Tree House

Complaints and Untoward Incidents

1. Amends to regional contracts for residential and nursing home care – requiring homes to report each complaint about the care of residents and the outcome of internal investigation
2. Mechanism for complaints to be communicated to Trust staff responsible for reviewing care of residents
3. Trusts to seek assurance that complaints have been resolved at contract review meetings
4. Improving accessibility and quality of information about making a complaint
5. Quality of investigations to be enhanced
6. Vulnerable Adult strategy meetings should identify those who should be interviewed
7. All organisations should ensure feedback to complainants is accurate and timely

Whistleblowing

8. NI Executive to Review the Public Interest Disclosure (NI) Order in light of the recommendations of the Whistleblowing Commission's report of November 2013
9. Minister to seek assurance that all health and social care organisations have robust whistleblowing policies and procedures in place
10. The Department of Health, Social Services and Public Safety to consider implementing best practice from other jurisdictions to protect Whistleblowers

COMMISSIONER'S ADVICE: Whole-system approach to a new Outcomes Framework for the Culture of Care Provision in NI

Care Standards & Inspections Processes

1. The rights, quality of life, dignity and care needs of vulnerable older people should be at the heart of planning, delivery, regulation and inspection of care services.
2. Standards for the care of vulnerable older people should be clearly displayed and available
3. Inspection processes should be more vigorous, with decisive and timely enforcement action when failings are detected
4. The regulation and inspection system should include a rating system

Enforcement

5. There should be clear and more rigorously applied sanctions against care providers for non-compliance
6. Persistent or serious breaches of regulation should result in decisive sanctions being applied without delay and within a defined timeframe
7. HSC Trusts should not continue to place older people in homes where there are unresolved compliance failures
8. New legislation to better protect older people from abuse should be enacted in NI without delay
9. HSC Trusts and Older People who self-fund should be entitled to a refund for any time care does not meet the standards

11. Each health and social care organisation to appoint a Champion for Whistleblowing issues
12. RQIA should assure itself that all Nursing & Residential Homes have a Whistleblowing policy in place that includes support and protection for whistleblowers
13. RQIA to comply with Guidance for Whistleblowers
14. Update training on Whistleblowing as required

Inspections

15. RQIA to ensure the Nursing Homes Minimum Care Standard on Continence Management is included regularly in the programme of inspections
16. RQIA should consider recruitment of lay inspectors who have worked in homes
17. Inspectors should adequately prepare for inspections by gathering all available information on complaints, incidents and concerns of whistleblowers
18. Inspectors should review intelligence prior to inspections and have authority to deviate from plan to address areas of concern
19. Evidence should be sourced directly during inspections on the compliance with standards and previous requirements
20. RQIA should consider how it can more effectively ascertain views of residents, family and staff during inspections
21. RQIA to review enforcement policy and procedures – UK
22. The Department of Health, Social Services and Public Safety should review Nursing Home Minimum Care Standards in relation to recruitment of staff

Whistleblowing and Protection

10. Whistleblowers and older people or relatives who raise concerns about poor care or abuse should be better supported and better protected from unfair treatment

A Cultural Change in Care

11. A well-trained and registered social care workforce, which is respected, valued and properly remunerated with opportunities for career progression, is essential.
12. Complaints processes, safeguarding procedures and details of the organisations which can assist complainants should be made clear to all prospective and current service users, their relatives and staff of care services.
13. The contract through which older people occupy care homes must be reviewed so that as long as the home can meet the assessed needs, they cannot be evicted without due process, reasonable due cause, and without appropriate alternative care being in place.

8. Stakeholders

- Age NI
- Age Sector Platform
- Alzheimer's Society
- Care and Social Services Inspectorate Wales (CSSIW)
- Care England
- Care Inspectorate Scotland
- Care Quality Commission
- Carers NI
- Independent Health & Care Providers (IHCP)
- Law Centre NI
- Lead of Operation Jasmine
- Concerned relatives, families, carers and friends of older people who approached the Commissioner's office after the Independent Review on the actions taken at Cherry Tree House
- Members of the Independent Review Team in relation to Care at Cherry Tree House
- Mencap/NHS whistleblowing helpline
- Northern Ireland Human Rights Commission (NIHRC)
- Northern Ireland Ombudsman
- Northern Ireland Public Service Alliance (NIPSA)
- Northern Ireland Social Care Council (NISCC)
- Patient Client Council (PCC)
- Patients First
- Royal College of Nursing (RCN)
- The Regulation and Quality Inspection Authority (RQIA)
- UK Homecare Association





Commissioner for **Older People**
for Northern Ireland

**Commissioner for Older
People for Northern Ireland**

Equality House
7-9 Shaftesbury Square
Belfast BT2 7DP

T: 028 90 890 892

E: info@copni.org

www.copni.org

ISBN: 978-0-9930725-3-6