ANNEX A

RESPONSES TO COPNI - REPORT INTO DUNMURRY MANOR CARE HOME

Safeguarding and Human Rights

No	COPNI Recommendation	Response	Comment
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. It remains arguable that a policy based approach may not be Human Rights compatible as it does not guarantee an appropriate level of protection. This was the point made by the reports on the statutory guidance in England and in Wales prior to new legislation coming into force.	**Ministerial decision required**	Advice formulated for incoming Minister.
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.	**Ministerial decision required**	Advice formulated for incoming Minister.
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. Such training must be specific rather than disconnected from more general training. The level of training should vary depending upon the nature of the duties undertaken and refresher courses should be undertaken regularly. Human rights should be an essential component of practitioner dialogue.	**Accepted**	(a) Trusts and the RQIA will review the bespoke training provided to their own staff to ensure it continues to comply with this recommendation and to provide an annual assurance it continues to do so; (b) The HSCB will explore the possibility of rolling out regional training for all non-Trust registered staff. In the future such requirements will be spelt out as part of the Regional contract; and (c) Promoting Human Rights is also part of core professional training for all health and social care registrants and staff.

R4	Practitioners must be trained to report concerns about care and treatment in a human rights context.	**Accepted**	Please refer to response against recommendation 3. This will be included in any training to be provided.
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.	**Accepted**	Trusts and the Department will ensure that all policies and procedures relating to the care of older people remain compatible with the European Convention on Human Rights. Thereafter as part of the annual assurance process, Trusts will formally confirm that all such policies and practices continue to be compatible with the Convention.
R6	The registration and inspection process must ensure that care providers comply with the legal obligations imposed on them in terms of human rights. An important component of the registration and inspection procedures, is to ensure that the human rights of people in care settings are protected and promoted. The Commissioner commends the approach of Care Inspectorate Wales (formerly the Care and Social Services Inspectorate Wales) in mapping individual rights to inspection themes and potential lines of enquiry. (CSSIW, Human Rights, 2017, a copy of which can be found at Appendix 3 of COPNI Report.)	**Accepted**	The RQIA will lead on the implementation of this recommendation.
R7	The Department or RQIA should produce comprehensive guidance on the potential use of covert and overt CCTV in care homes compliant with human rights and data protection law.	**Ministerial decision required**	Advice formulated for incoming Minister.

Care and Treatment

No	COPNI Recommendation	Response	Comment
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 Accepted contract between both parties.	**Accepted**	Recommendation is accepted. However it should be noted that Trust Directors of Nursing are not the only Directors with responsibility for commissioning of care in the independent sector. All Trust Directors with responsibility for commissioning will take all reasonable steps to ensure that care being commissioned for their population is safe and effective and there are systems in place to monitor this effectively. The Department has commissioned the development of a Nursing Assurance Framework which will include nursing services commissioned and provided by the Independent sector.
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.	**Accepted**	HSC Trusts will work with relevant care homes to build on existing procedures and move to a regional single care plan format personalised to each service user. Homes will be responsible for updating and maintaining care plans as required and where the appropriate authority exists, homes will be required to share the care and treatment plans with families on request.
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)."	**Noted**	This will be taken forward by the Department as part of the Inquiry into Hyponatraemia Related Deaths Implementation.
R11	The Commissioner reiterates Recommendation 32 from the Inquiry into Hyponatraemia-related Deaths that Failure to report an SAI should be a disciplinary offence.	**Noted**	This will be taken forward by the Department as part of the Inquiry into Hyponatraemia Related Deaths Implementation.

R12	Failure to have an initial six week care review meeting should trigger a report in line with SAI procedures.	**Partially Accepted**	Under the current care management guidelines, this is not a requirement, but is considered best practice. The HSC agree that if a 6 week review does not happen a need for escalation is required, however establishing an SAI may not be the appropriate response. There will be circumstances where flexibility will be required.
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.	**Accepted**	RQIA will take the lead in the implementation of this recommendation including full implementation of Personal Public Involvement (PPI) requirements and DOH Co-Production Guidance.
R14	The movement of residents by relatives to other 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.	**Accepted**	Each Trust in conjunction with the HSCB, will develop a local and regional system to ensure this type of intelligence is captured, analysed and shared with the RQIA for improvement opportunities. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.
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 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	**(a) Partially Accepted** **(b) Ministerial decision required**	(a) Each Trust should review the support and information provided to older people and their families when facing a decision to place a relative into a care home, including the feasibility of allocating a senior health professional to oversee these placements and good practice. (b) In respect of the introduction of a ratings system, the department has considered this recommendation and formulated advice for an incoming minister.

Medicines Management

No	COPNI Recommendation	Response	Comment
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.	N/A	**For Runwood Care Homes Ltd to respond.**
R17	Care must be taken by staff to ensure any medicine 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.	**Accepted**	The Department, HSCB and Trusts through the Regional Discharge Group will consider carefully the implications of this recommendation and revise existing policy and guidance as accordingly.
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.	**Accepted**	Trusts will lead on the implementation of this recommendation across all Nursing homes in the Province, engaging the Medicines Optimisation in Older People (MOOP) network as necessary. It is acknowledged the approach is very much a shared-decision making one involving the patient and/or family or carers but should at all times respect the privacy of the resident.

R19	Staff should ensure it is clearly documented on each occasion why a resident might not be administered a medication.	**Accepted**	The Department in conjunction with Trusts and Care Providers will consider how best to implement this recommendation.
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.	**Accepted**	The Department will lead a review of existing policies, guidance and procedures and implement updates as necessary to ensure compliance with this recommendation.
R21	The RQIA Pharmacist inspectors need to review all medication errors reported since the previous inspection and review the Regulation 29 reports in the home to ensure steps have been taken to improve practice.	**Accepted**	RQIA inspectors will review all notifiable incidents as they are reported.

Environment and Environmental Cleanliness

No	COPNI Recommendation	Response	Comment
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). This must form part of periodic inspections to ensure suitability is maintained.	**Ministerial decision required**	Advice formulated for incoming Minister.
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.	**Accepted**	Premises are already a routine component of RQIA Care inspections. Care Inspectors undertake an inspection of a sample of residents' rooms as well as communal areas.
R24	Runwood must devolve goods and services budgets to a local level for staff to manage.	**N/A**	**For Runwood Care Homes Ltd to respond.**
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.	**Ministerial decision required**	Advice formulated for incoming Minister.
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.	**Ministerial decision required**	Advice formulated for incoming Minister.
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.	**Ministerial decision required**	Advice formulated for incoming Minister.

Regulation and Inspection

No	COPNI Recommendation	Response	Comment
R28	Integrated inspections which cover all of the lived experience of residents should be introduced by the RQIA as soon as possible.	**Accepted**	RQIA will take the lead on the implementation of this recommendation.
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.	**Accepted**	Work has already begun across the HSC on this issue. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.
R30	RQIA need to review their inspection methodology in order to access reliable and relevant information from residents and their families.	**Accepted**	RQIA acknowledges that one of the unforeseen consequences of moving to unannounced inspections is the lack of opportunity for families and carers to speak to inspectors. RQIA is currently undertaking a review of all aspects of its inspection processes with support from Care Inspectorate Scotland.

R31	RQIA inspectors must engage effectively with staff, especially permanent staff, in order to glean a more comprehensive view of the home being inspected.	**Accepted**	RQIA is currently undertaking a review of all aspects of its inspection processes. Inspectors do speak to a range of staff during all inspection visits and RQIA are exploring the introduction of a pilot mechanism whereby staff can provide intelligence to inspectors on care issues through their trade union representative.
R32	The use of lay assessors/ inspectors in the inspection of care settings for older people should be introduced.	**Accepted**	This is already in place with lay inspectors having taken part in 60 inspections to date during 2018/19. RQIA are actively recruiting more lay assessors to increase this role.
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.	**Partially Accepted**	The current legislation sets a limit of 90 days and RQIA can extend this if there is evidence of sufficient improvement. Trusts can impose sanctions (cease admissions) and RQIA will formally seek the view of Trusts that they are satisfied with any potential extension. The Department is currently reviewing the 2003 legislation and this includes a review of the enforcement powers and sanctions open to RQIA. A Departmental reference Group with all relevant policy leads, feeds into this work. However, we are not clear that immovable deadline would necessarily be in the best interests of residents and their families.

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.	**Accepted**	RQIA is currently undertaking a review of all aspects of its inspection processes including out of hours inspections with a view to increasing the numbers in response to intelligence. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.
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.	**Ministerial decision required**	Advice formulated for incoming Minister.
R36	The system of financial penalties should be strengthened and applied rigorously to providers of independent care homes which exhibit persistent or serious breaches of regulations.	**Ministerial decision required**	Advice formulated for incoming Minister.
R37	The RQIA should have a statutory role in ensuring that complaints are actioned by care providers to the satisfaction of complainants.	**Ministerial decision required**	Advice formulated for incoming Minister.

Staff Skills, Competence, Training and Development

No	COPNI Recommendation	Response	Comment
R38	The Department / Chief Nursing Officer (CNO) as the commissioners of pre-registration nurse education should ensure workforce plans are developed that take full account of nurse staffing requirements for the independent sector.	**Accepted**	The Department will lead in the roll out of this recommendation and commits, to ensuring that appropriate workforce plans are developed.
R39	The Chief Nursing Officer as a matter of priority should undertake a workforce review and commission work to design tools to measure nurse workforce levels required in the independent sector in Northern Ireland i.e. normative staffing level guidelines and the minimum standard staffing guidance revised accordingly.	**Accepted**	Although an overall Nursing Workforce Review was completed the CNO has commissioned Phase 8 of 'Delivering Care' Programme (normative nursing) for the independent sector which once developed will be used to ensure safe staffing in the independent sector.
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.	**Accepted**	Phase 8 (normative nursing), for the independent sector is currently being developed as outlined in Recommendation 39 (and once developed and agreed) RQIA will inspect against the amended standards.

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. Staff turnover should be monitored and findings of high levels of staff attrition 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.	**Ministerial decision required**	Advice formulated for incoming Minister.
R42	Trust Executive Directors of Nursing, as commissioners of care in the independent sector should ensure that there are sufficient numbers of nursing staff with specialist knowledge to deliver safe, effective and compassionate care in the independent sector and assure themselves through the contract agreements with providers.	**Accepted**	Trust Directors of Nursing are not necessarily the commissioners of care in the Independent Sector. The Trusts will work with the Department, RQIA and the Independent Sector to monitor existing guidance for staffing in care homes. As part of commissioning arrangements Independent Sector providers will be required as part of Phase 8 Delivering Care Programme to ensure safe and effective staffing. The commissioning specification will also include an outline of the specialist knowledge and skills required by providers. Trusts will monitor staffing levels as part of the New Nursing Assurance Framework (underdevelopment) as set out in Recommendation 8 and work in partnership with Independent sector providers to provide specialist nursing in-reach support as required by the need of residents.
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 review exit interviews.	**Ministerial decision required**	Advice formulated for incoming Minister.
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.	**N/A**	For Runwood Care Homes Ltd to respond.

Management and Leadership

No	COPNI Recommendation	Response	Comment
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).	**Ministerial decision required**	Advice formulated for incoming Minister.
R46	Any reports of inappropriate behaviour by senior managers in the independent 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".	**Ministerial decision required**	Advice formulated for incoming Minister.
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.	**Ministerial decision required**	Advice formulated for incoming Minister.
R48	Relatives / residents who raise concerns which are not resolved locally should have their complaints handled by the commissioning Trust or the RQIA (see Section 8 on Complaints and Communication of COPNI Report).	**(a) Accepted** **(b) Ministerial decision required**	(a) Escalation process already in place but will be reviewed but RQIA are not part of the process As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC. (b) Advice formulated for incoming Minister.

Complaints and Communication

No	COPNI Recommendation	Comment	Proposed Response
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. Families should be given meeting dates well in advance rather than requesting a meeting themselves. If a meeting has to be cancelled due to unforeseen circumstances this should be communicated to the families promptly.	**N/A**	For Runwood Care Homes Ltd to respond
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.	**Accepted**	HSCB collates all complaints made to HSC Trusts and a multi-disciplinary group reviews these monthly. An annual Complaints Report is published and every year the HSCB host a 'Learning from Complaints' regional event. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.
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 a home. They must then use this access to track patterns and look at the detail of complaints that are indicative of serious concerns.	**Accepted**	HSCB collates all complaints made to HSC Trusts and a multi-disciplinary group reviews these monthly. An annual Complaints Report is published and every year the HSCB host a 'Learning from Complaints' regional event. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.

R52	Complaints statistics relating to care homes should be published annually and be made publicly available, subject to adherence to appropriate data protection protocols.	**Accepted**	HSCB collates all complaints made to HSC Trusts and a multi-disciplinary group reviews these monthly. An annual Complaints Report is published and every year the HSCB host a 'Learning from Complaints' regional event. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.
R53	A duty of Candour (see Section 9) must be introduced to provide a transparent and meaningful learning process from complaints.	**Noted**	This will be taken forward by the Department as part of the Inquiry into Hyponatraemia Related Deaths Implementation.
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.	**Noted**	PCC and The NIPS Ombudsman are in place to handle such issues and all whistle-blowers are subject to the relevant protection of the Public Interest Disclosure (NI) Order 1998. Our view is that these mechanisms remain appropriate and relevant.

Accountability and Governance

No	COPNI Recommendation	Response	Comment
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.	**Accepted**	Work has already begun across the HSC on this issue. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.
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.	**Accepted**	The Statutory duty of Quality and Adult Safeguarding Policy is already in place. The regional contract specifies the requirements for governance and accountability for the Independent Sector providers. However we will work with the HSCB and Trusts on how effective delivery of this is enhanced.
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.	**Noted**	This will be taken forward by the Department as part of the Inquiry into Hyponatraemia Related Deaths Implementation.
R58	The Regional Contract should be reviewed and training provided in relation to its content and effective use of its terms. The Department of Health should conduct a review of whether this contract is adequate in terms of being able to enforce the performance obligations contained therein.	**(a) Accepted** **(b) Ministerial decision required**	(a) Annual review led by HSCB to consider; and (b) Advice formulated for incoming Minister.

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.	**Accepted**	An effective Early Alert System is already in place and its importance will be reinforced through a HSC Workshop. As part of the Department's Independent Review, it is expected that the review team will consider the effectiveness of communication across the HSC.