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

Home Truths:

A Report on the Commissioner's Investigation into Dunmurry Manor Care Home

JUNE 2018

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Dedication

This report would not have been possible without the valuable contributions of the families and friends of residents, both past and present, of Dunmurry Manor Care Home. Some relatives and families did not wish to be interviewed and it is hoped that this report does not cause distress for any family member with a relative in the home.

The experiences of those relatives who contributed, which in many cases were very difficult to re-live, are at the heart of this report. The investigation team found the testimonies both invaluable and powerful. It was very clear that the main priority of all those interviewed was the compassionate care and day-to-day wellbeing of their loved one.

Their experiences gave the team a clear sense of the lived experience of older people in Dunmurry Manor Care Home. This report is published for all of those who gave up their time and effort, contributing to the investigation in the hope that these events will never be repeated, both now and for future generations.

1.0 Commissioner's Foreword

"The true measure of any society can be found in how it treats its most vulnerable members."

Mahatma Gandhi

This report outlines both the findings of my investigation into the standards of care received by residents of Dunmurry Manor Nursing Home (Dunmurry Manor) since it was set up in 2014 and a series of recommendations to improve the quality of care of older people residing in care homes.

I commenced this investigation after my office received a number of complaints and concerns. These came from both family members and former staff about what was happening in Dunmurry Manor and their concerns about the quality of care provided to older people there.

This is the first time my office has used its statutory powers of investigation to examine an issue and it was a decision I considered very seriously. After carefully reviewing the circumstances being reported to my office I came to the conclusion that this was a matter so serious that it was potentially affecting the everyday lives of more than 70 residents in Dunmurry Manor.

Regrettably, this report outlines a disturbing picture where there were many significant failures in safeguarding, care and treatment which led to many of the residents not receiving adequate protection for prolonged periods of time. It reveals a system that is disjointed and failing in its duty to provide the care and protection that residents of Dunmurry Manor were entitled to. It shines a light on a home where despite multiple concerns being raised repeatedly by families, care home staff, Health and Social Care (HSC) Trust employees and others, there was a slow and inadequate response from the authorities involved in ensuring that minimum standards of care were being met.

The report is entitled, ***Home Truths*** as it is my view that the investigation has uncovered the heartbreaking reality of the lived experience of the residents of Dunmurry Manor since it opened in 2014.

It is essential that the quality of care provided to older people living in care homes across Northern Ireland is maintained at a high level. These are some of our most vulnerable older people and it is inexcusable for standards to drop to levels that can put their wellbeing at risk.

It is vital that all the organisations responsible for providing care respond swiftly to the findings in this report to assure the public that it can trust in the care being provided to tens of thousands of older people across Northern Ireland.

My office previously issued a report in 2014, *Changing the Culture of Care Provision*, which made a number of recommendations to improve standards in care settings in Northern Ireland. These included recommendations to make the inspection process more rigorous, to introduce and implement clear sanctions, as well as specific adult safeguarding legislation and better protection for whistleblowers and improved complaints processes.

In the same year, the independent review report on the Cherry Tree Nursing Home in Carrickfergus also revealed serious shortfalls in the standard of care and the inspection regime. At the time, there were a number of public commitments made to bring about change and to implement a series of recommendations to prevent a repeat of this happening in the future.

Unfortunately, the response to these recommendations has been slow and disjointed, the result being that many of the failures identified in this investigation could have been prevented or at least managed better had the previous findings and recommendations been acted on more quickly and in full.

It is vital that we can have confidence in our health and social care system and this must include care provision in later life. If the public are to be reassured that those who live in care homes are receiving good quality care, 24 hours a day and 365 days a year, then the findings of this investigation must be responded to as a matter of urgency. Not only that, but Government must advise which recommendations of this report it will implement and by when.

While I appreciate that no organisation likes to be under the spotlight of an investigation of this type, I was disappointed by the defensive and sometimes unhelpful nature of some of the relevant authorities. I believe that this investigation could have been concluded more quickly had some relevant authorities adopted a more co-operative approach from the outset.

Nevertheless, what is important now is that each relevant authority carefully considers the findings and recommendations emerging from this investigation and responds to me in a timely and constructive manner. This issue is too important to simply put on a shelf or commit to making plans further down the line. Many of the findings and recommendations must be addressed now and clear action plans put in place to show how progress can be made on the key issues.

I was pleased with many of the witness testimonies from people working in the sector during the course of the investigation who showed a genuine desire to change things for the better. This gives me some reassurance that those who put the needs of older, vulnerable people at the forefront of their minds will respond positively to these findings and develop a renewed vigour to tackle the challenges that exist and raise standards of care.

This investigation has revealed a culture where communication between the various authorities responsible for delivering care to older people is

fractured and confusing, which in turn leads to delays in taking necessary actions to ensure safety and good quality care.

There is a strong need to review the complaints processes and culture that exist in relation to care homes. Many people who gave evidence described a system of fear and helplessness where they believed that making a complaint was at best, pointless and at worst, counterproductive.

This must change.

We need to change the culture to one where there is a clear duty on all authorities to be open and honest with residents and their families in relation to the care of their loved ones no matter in what setting they find themselves.

The recent *Report of the Inquiry into Hyponatraemia[1]related Deaths* recommended a statutory duty of candour where every health and social care organisation and everyone working for them must be open and honest in all their dealings with their patients and the public. I fully support this call as it would help address some of the concerns emerging from this investigation.

This investigation coincided with the recent suspension of the devolved administration of Northern Ireland. The COPNI 2011 Act requires me to provide advice to the Secretary of State for Northern Ireland and to the Executive Committee of the Northern Ireland Assembly. I have provided this report to the Secretary of State for Northern Ireland, the Rt. Hon. Karen Bradley MP. I have also provided a copy of the report to the Head of the Civil Service, in his capacity as Secretary to the Executive Committee.

I would like to thank my expert panel of advisers, Eleanor Hayes, Dr. Robert Peat and Professor John Williams for their invaluable input, expertise and dedication throughout the course of this investigation. Their insight and knowledge into nursing, regulation, safeguarding and human rights was key to the analysis of the evidence that emerged from the investigation and provided me and my team with confidence in reaching evidence-based conclusions.

Finally, I would like to pay special thanks to all the families and friends of residents of Dunmurry Manor, both present and past, for their generosity in providing evidence and for their patience and support in waiting to hear the outcome of the investigation. I am determined that your contribution will make a difference, not only for your loved ones, but for all older people living in care homes throughout Northern Ireland so that they will receive better care and protection in future.

Eddie Lynch
Commissioner for Older People for Northern Ireland

[1] *The Inquiry into Hyponatraemia-related Deaths: Report*, January 2018

2.0 Executive Summary

Commissioner for Older People for Northern Ireland's Legal Powers and Duties

The Commissioner for Older People (Northern Ireland) Act 2011 (COPNI Act 2011) grants a range of powers and duties to the Commissioner to promote and safeguard the rights and interests of older people.

Prior to this investigation, the Commissioner relied on the more informal powers of advocacy and alternative dispute resolution when dealing with cases brought to his office.

In February 2017, the Commissioner exercised his discretion to commence a statutory investigation into specific matters affecting older people.

Background

Dunmurry Manor is a 76 bed residential and nursing home located in Dunmurry, Belfast, owned and operated by Runwood Homes Limited (Runwood). Specialising in dementia care, the home opened in 2014. In November 2016 the Regulation, Quality and Improvement Authority (RQIA) issued three notices of Failure to Comply which set out the actions required by Dunmurry Manor to achieve compliance with Nursing Home Regulations by early January 2017 i.e. a period of 90 days.

In December 2016, two families contacted the Commissioner's office in relation to concerns about their relatives' treatment in Dunmurry Manor and the lack of satisfactory response that they received in relation to their complaints. Within the same month, the Commissioner was also contacted by two former members of staff of Dunmurry Manor. Both whistleblowers alleged poor and unsafe practice within the home.

It was at this time that the Commissioner was invited to a public meeting convened by Community Restorative Justice Northern Ireland[2] to discuss concerns about Dunmurry Manor and other care homes in the area. At this meeting, the Commissioner's team listened to families' experiences, some of which alleged significant and serious failures of care. Furthermore, the three notices of Failure to Comply were not removed by the end of January 2017 (the 90-day period given under the RQIA's enforcement policy, to make improvements).

Before making the decision to commence an investigation, the Commissioner sought assurances, as required by the COPNI Act 2011, that no other organisation intended to or was better placed to conduct an investigation into Dunmurry Manor.[3]

[2] Information about CRJNI http://www.nicva.org/organisation/community-restorative-justice-ireland-central-office

[3] The full background and methodology of the investigation can be found in Annex I at the end of the report

Purpose

The purpose of the investigation was to seek evidence from past and present residents, their families and employees of Dunmurry Manor about their experience of the care and treatment provided there[4]. The Commissioner has examined the actions taken by the Relevant Authorities (RAs) including Dunmurry Manor and its parent company Runwood, the regulator (RQIA), the Department of Health (the Department) and the Health and Social Care Trusts (HSC Trusts) which placed residents in the home. The Commissioner welcomed evidence of both good and poor practice as well as other comments.

On the basis of the investigation findings the Commissioner has made a number of recommendations addressed to each of the RAs.

Findings of the Commissioner's Investigation into Dunmurry Manor

The investigation findings are deeply concerning and reflect an environment of poor care and treatment, serious safeguarding issues and medicines management issues, compounded by a failure of responsible bodies (RAs) to act quickly and comprehensively.

Evidence of physical and sexual assaults on female residents, residents leaving the home unnoticed and multiple instances of inhuman and degrading treatment were witnessed and reported.

Despite Dunmurry Manor being regulated against care home standards within a regime of regulation and inspection, harm still occurred. It became clear as the investigation progressed that none of the organisations involved were aware of the full scale of the issues being experienced by residents in the home.

Within this report there are 61 findings across nine key themes:

- Safeguarding and Human Rights
- Care and treatment
- Medicines management
- The environment and environmental cleanliness
- Regulation and inspection
- Staff skills / Competence / Training and development
- Management and leadership
- Complaints and communication
- Accountability and governance

Recommendations

Older people in Northern Ireland and their families must be able to be confident that they can depend on the care that will be provided in a care home. Many families already find it extremely difficult to trust someone else to provide their loved one's care. Failures such as those found in Dunmurry Manor undermine public confidence making this decision even harder. The Commissioner must be satisfied lessons have been learnt. He seeks assurance that the legal framework, processes and procedures as well as the system of regulation and inspection, will undergo significant change.

The 59 recommendations made by the Commissioner are addressed to the RAs and pertain to the nine key themes of findings. The recommendations seek to improve care and bring about significant change within the system, in the hope that the level of failings found within Dunmurry Manor cannot be repeated.

[4] See Appendix 1 for full version of Terms of Reference

Next Steps

In accordance with the COPNI Act 2011 there are a number of next steps that must be taken following publication of this report. The Commissioner will notify all of the RAs of the recommendations contained within this report. He will provide them with a period of three months to respond in accordance with the requirements of the COPNI Act 2011. The Commissioner will publish the RAs responses and his review of the response in due course.[5]

The Commissioner expects the RAs to address the findings and recommendations and to provide clear action plans on how they propose to take forward the necessary improvements without delay.

[5] Section 4(1)-(5c) COPNI Act (Northern Ireland) 2011

3.0 The Expert Panel

The Commissioner appointed a panel of three experts to provide advice and guidance throughout all stages of the investigation.

The panel provided expertise on areas including older people's nursing care, regulation, inspection and commissioning of care, safeguarding older people and human rights.

Contacts in academia, the Royal College of Nursing and previous experts engaged by the Commissioner were asked for their advice regarding relevant experts who would be deemed to be sufficiently independent from the care system in Northern Ireland.

Each of the expert panel members appointed, possess relevant experience of implementing standards and procedures in a care home environment, in safeguarding and human rights law relating to older people, and experience of working in care home inspection and helping set regulation and inspection processes.

They are all independent of the RAs being investigated. The role of the expert panel in this investigation was to:

- Provide their definition of what constitutes 'good quality care', to inform the investigation interviews and the report
- Review the themes emerging from interviews
- Assist the development of the investigation process
- Identify key issues emerging from the investigation from their relative areas of expertise
- Review and advise on investigation findings and appropriate recommendations
- Provide expert guidance to the Commissioner throughout the investigation
- Advise on the drafts of the report and recommendations to the Commissioner

Expert Panel Members

Eleanor Hayes
RGN BSc. Nursing MSc.
(Nursing and Care)

Eleanor Hayes is a former Executive Director of Nursing in the Belfast City Hospital and Green Park Healthcare Trusts with over 40 years experience working within health and social care in Northern Ireland. She is a Registered General Nurse and has a MSc in Health and Social Care Management.

In 2007 Eleanor established Hayes Healthcare Consulting as an independent consultant and has been working since then within the public, private and voluntary sectors across Ireland. Her main focus of work has been in conducting service reviews, investigating serious adverse events and advising organisations in relation to their corporate governance activities. She was a member of the Public Inquiry panel which reported on the C. Difficile outbreak in the Northern HSC Trust in 2008. In 2014, she was a member of the panel which reviewed the actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus.

Professor John Williams
Safeguarding and Human Rights

John Williams is a Professor of Law at Aberystwyth University. He is the author of many papers on the rights of older people, social care of older prisoners, the case for a public law on the protection of adults at risk, care home design and human rights, and international human rights and older people. He is the author of Protection of Older People in Wales: A guide to the Law, published by the Older People's Commissioner for Wales. He has presented papers at conferences including the American Bar Association, the British Psychological Society, the International Association of Law and Mental Health, the Irish-Scottish Forum, Action on Elder Abuse and the International Congress of Psychology and Law.

He is a regular presenter at Harvard Medical School's Program in Psychiatry and the Law. In 2012, he was appointed to the United Nations Panel of experts advising on international human rights and older people. He regularly advises the Older People's Commissioner for Wales on the rights of older people. John is one of the co-chairs of the Domestic Homicide Review Panels in Ceredigion and Pembrokeshire. John has been a trustee of Age UK and Age Scotland. He advised the National Assembly for Wales and the Welsh Government on the Social Services and Well-being (Wales) Act 2014.

Dr Robert Peat
Regulation, Inspection and Commissioning

Robert Peat graduated from the University of Strathclyde in 1980 with a BA in Sociology and Administration. He obtained his PhD from the University of Aberdeen in 1984.

Robert retired from the Scottish Care Inspectorate in May 2016 where he had worked for three years. He was the Director of Inspection and latterly the Executive Adviser to the Board of the Inspectorate.

A social worker for over 30 years, Robert's main career was in Local Government in the Tayside area of Scotland. He became Director of Social Work and Health with Angus Council in 2003 and from 2006 was also the Deputy Chief Executive of the Council, a role he fulfilled alongside his duties as Director of Social Work and Health. Robert left Angus Council in 2013.

Robert was appointed as a Non-Executive Member of NHS Tayside Board and took up this position on 1st January 2017. This is a 4 year appointment.

Each of the nine sections which follow outline conclusions, context (including legislation and standards), case studies and then findings and recommendations.

4.0 Findings: by Theme

4.1 Safeguarding and Human Rights

Conclusions: Safeguarding and Human Rights

The evidence gathered during the investigation supports the following conclusions:

- The most important theme emerging from the investigation, and one which covers a broad range of issues, is safeguarding. This theme is about the importance of protecting those most vulnerable in our society.
- Most of the residents in Dunmurry Manor were vulnerable adults at risk of harm as defined in the 2015 Adult Safeguarding Prevention and Protection in Partnership Policy (the 2015 Policy). Their personal characteristics and life circumstances resulted in their exposure to harm through abuse, exploitation or neglect being increased.
- Many of the residents in Dunmurry Manor were adults in need of protection. They were unable to protect their own wellbeing and rights, and the action or inaction of another person or persons, of the RAs under investigation, caused them to be harmed.
- The findings show that there was a clear and immediate risk of harm. Evidence gathered demonstrates this abuse materialised in the form of physical abuse, psychological abuse, institutional abuse and neglect.

Legislation and Standards

It is helpful to set the context for the findings and evidence by looking at the framework which governs the policy and practice in this area currently.

The adult safeguarding framework for Northern Ireland is found primarily in the 2015 Policy, issued by the then Department of Health, Social Services and Public Safety, (DHSSPS), and the Department of Justice.

Standard 13 of the Care Standards for Nursing Homes (April 2015) requires that residents *'feel safe and are safe in the care of the home. Arrangements are in place to safeguard them and to protect them from harm…They are protected from all forms of abuse, neglect, exploitation, and serious harm – including online.' It also states that 'all incidents of actual, alleged or suspected abuse, neglect or exploitation are promptly reported in line with departmental policy on adult safeguarding.'*

Unlike England, Scotland and Wales, there is no adult safeguarding legislation in Northern Ireland. Instead the protection of older people in Northern Ireland depends on the implementation

and interpretation of the 2015 policy document. The 2015 policy recognises that adult safeguarding is based on fundamental human rights, involving the need to focus intervention on promoting a proportionate, measured approach to balancing the risk of harm and respecting the adult's choices. It emphasises the importance of partnership working, and that safeguarding is the responsibility of a wide range of agencies, organisations, and individuals. The adult safeguarding policy recognises that adult safeguarding is *'principally the responsibility of Health and Social Care Trusts and the Police Service of Northern Ireland.'*[6] Some of the 2015 policy's aims are outlined below, including the need to,

> *'establish clear guidance for reporting concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be responded to;*
>
> *promote access to justice to adults at risk who have been harmed as a result of abuse, exploitation and neglect;' (p.7)*

The 2015 policy defines 'adult at risk of harm' and 'adult in need of protection' as follows:

> *'An Adult at risk of harm is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:*
>
> *a) personal characteristics*
>
> *AND/OR*
>
> *b) life circumstances*
>
> *Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.'*
>
> *'An Adult in need of protection is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their':*
>
> *a) personal characteristics*
>
> *AND/OR*
>
> *b) life circumstances*
>
> *AND*
>
> *c) who is unable to protect their own well-being, property, assets, rights or other interests;*
>
> *AND*
>
> *d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed. (p.10)*

The following definitions in the 2015 policy are used to describe the categories of harm:

> *Harm is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.*
>
> *Abuse is 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights'.*
>
> *Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force-feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty.*
>
> *Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/ non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.*
>
> *Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.*
>
> *Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk.*

A number of residents' families and former staff of Dunmurry Manor who were interviewed gave detailed examples of incidents and events which contributed to the safeguarding findings detailed later in this chapter. Anonymised case study examples taken from witness evidence are provided throughout the report to give some context for the scale of the investigation findings and the lived experience of residents in Dunmurry Manor over a period of time.

[6] Page 4 of the ASG policy https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

Resident A

Resident A (Res A) was 88 years old and living with dementia. Res A had been living at home until hospitalised after a number of falls. Res A was discharged to rehabilitation and then assessed as requiring nursing care and was placed in the Dunmurry Manor nursing unit.

The family felt the home and particularly the nursing unit was busy and chaotic from the start. They noted the high turnover of managers (there were five during their relative's time in the home) and nursing staff. It was their experience that staff were regularly seen sitting in the dining room or lounge doing their paperwork. Buzzers were not answered. Res A's dentures and wedding ring went missing. Res A's family raised concerns about the personal care and continence support.

Res A suffered a number of serious incidents. The first was an injury caused by a fall which required 17 staples to Res A's head. The family stated that the then Manager asked them not to bring a formal complaint as lessons had been learnt.

Res A was then the victim of a suspected sexual assault by another resident followed shortly thereafter by another unwitnessed and unexplained incident when Res A was found lying on the floor of the other resident's room.

Neither incident was properly reported or dealt with to the family's satisfaction.

There were delays in notifying the PSNI and HSC Trusts' safeguarding teams after the first incident. There was a failure to place the alleged perpetrator under one-to-one supervision and/or close observation following the first suspected sexual assault. Dunmurry Manor failed to call an ambulance after the second incident and the family had to insist that this was done.

Although investigations have been conducted by both the HSC Trust and Dunmurry Manor following the second incident, the family remained dissatisfied by the delays and their experience of *"not being taken seriously"*. They remain of the view that their relative was not adequately protected on both a proactive and a reactive basis.

They believe management only acted when matters escalated to a point of *"crisis"* and that they had *"a hard fight"* to get the care their relative needed and deserved.

The family has compared and contrasted their relative's and their own experience of Res A's new care home as being dramatically different. The new care home is *"proactive"* and staff there have brought their loved one *"out of their shell"* doing *"little things"* to make them feel so much more content.

Resident R

Resident R (Res R) was a 72 year-old who had been living with dementia. They had previously resided in another care home and would walk from *"morning until night."*

Res R's relative first became concerned when they arrived at Dunmurry Manor with Res R and no one had received the message that they were arriving. A staff member asked *'what's [Res R] doing here?'* There were no documents prepared.

The relative soon had concerns in relation to continence care. They arrived to find a strong smell of urine. The relative found that Res R was soaked in urine. Res R was not wearing a pad and was soaked through their underwear, socks and shoes.

Res R was admitted to hospital in March 2016. It became apparent that their neck muscles had wasted and Res R remained in bed after that. This was only three weeks after their admission to Dunmurry Manor. The relative was told by hospital staff that Res R had a grade 2 pressure sore on her sacrum. This was the first time that the relative had been made aware of this information.

Res R returned to Dunmurry Manor and had a care review in October. A nurse examined Res R and found that the pressure sores were *"ungradable – they were down to the bone"*. The nurse said these were the worst pressure sores she had ever seen. When the sores were swabbed tests confirmed there was an E Coli infection present. Management was not aware that there was an E Coli outbreak in the nursing wing of Dunmurry Manor.

Morphine was prescribed for Res R. However, this was only given after their dressing was changed when Res R was already shaking with pain. Res R's relative was very concerned about the lack of pain relief given to Res R despite their *'very extreme pain.'* The relative remained concerned about pain relief right up until Res R passed away. The relative stated 'the week [Res R] passed away I was told that [staff member] would get a [syringe] driver that day. The district nurse had to come and show [the nurse] how to work it and come back the next day. Res R showed signs of pain that night and I asked that [staff member] who said Res R could have nothing else because they had a [syringe] driver. Spoke to [the GP] the next day and they said *"no, [Res R] should have had something [for the pain]."*

The relative had to pick up Res R's newly prescribed medication despite repeated promises that it would be collected by staff. On one occasion the relative arrived to find a soiled continence pad about three inches

Resident R *(continued)*

from Res R's head, very close to Res R's face. The relative asked for a nurse to come and waited a further 20 minutes for someone to arrive.

Res R had been using an airflow mattress. This regularly stopped working and on occasions the relative found it switched off or unplugged. The relative was concerned as Res R was not wakened for food or drinks, their hair became increasingly dirty and their teeth were crusted-over.

When the relative asked why staff did not wash Res R's hair anymore they were told it was because Res R *"is bedridden"*. The relative tried to drip juice into Res R's mouth and described that Res R *"bit down on my finger as [Res R] was so thirsty."*

The relative also raised concerns as Res R was not kept at a 30 degree tilt or turned hourly (in line with the care plan). The relative asked about activities for Res R and a special chair to allow Res R to sit in the main area with other residents. This did not happen and Res R remained alone in their room.

Res R was struggling to breathe one evening and the relative asked for a nurse to assist. The relative described the nurse as *'fantastic'* but when he arrived with the oxygen tank and blood pressure cuff he realised the tank was empty and the cuff did not work.

Res R's relative stated that Res R was *"locked in a bedroom and left to die with no quality of life."*

The Implications of the European Convention on Human Rights

Under s.6 of the Human Rights Act 1998 it is *"...unlawful for a public authority to act in a way which is incompatible with a Convention right."* A public authority, for the purposes of the Act, is defined as *"any person certain of whose functions are functions of a public nature."* This definition includes the RQIA and the six[7] Health and Social Care Trusts in Northern Ireland (HSC Trusts). Any legislation applying to these public bodies must be interpreted in a way *"which is compatible with the Convention rights."* This is regardless of whether the legislation was passed prior to the Human Rights Act 1998 or after its implementation. The application of the European Convention on Human Rights to RQIA and the six HSCTs is clear. In addition to the requirements of their parent legislation, the s.6 Human Rights Act 1998 duty applies.

The Commissioner is also a public authority, bound by the Human Rights Act 1998. In addition, s.2(3) COPNI Act 2011 requires the Commissioner to *"have regard"* to the United Nations Principles for Older Persons, adopted by the United Nations General Assembly in 1991. The United Nations Principles refer to Independence, Participation, Care, Self-fulfillment and Dignity. The Commissioner has had regard to these principles during this investigation.

The human rights duty of private bodies who provide residential, nursing or domiciliary care on behalf of bodies such as the six HSC Trusts in Northern Ireland was clarified by s.73(1)(d) of the Care Act 2014[8]. Although primarily England based legislation, this provision applies across all four nations of the United Kingdom. Under this provision, where a Health and Social Care Trust pays or arranges for a person registered under Part 3 Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to provide services under Article 15 Health and Personal Social Services (Northern Ireland) Order 1972, that person will be deemed to be exercising the function of a public authority for the purposes of the Human Rights Act 1998.

Consequently, providers of care homes such as Runwood are bound by the Human Rights Act 1998 and the European Convention on Human Rights. As with the RQIA and the HSC Trusts, the quality of its provision must be assessed according to the Convention rights.

Although public authorities must respond when they identify a violation of a person's human rights, there is also a requirement that they are proactive and positively promote rights. Thus, human rights must be embedded in all procedures, policies and practice. They must also be embedded in the culture of public authorities and, in relation to provision in care homes, they must underpin the ethos.

Appropriate levels of staffing and adequate facilities to ensure dignity and respect are essential. However, treating the person as an individual and

[7] Page 4 of the ASG policy https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

[8] Originally provided by Section 145 of the Health & Social Care Act 2008 which was repealed

ensuring that staff and others treat them with respect and courtesy and do not treat them as being less deserving is essential. Resources are important, but they are not everything.

The key rights in the European Convention are:

- Article 2: The right to have life protected
- Article 3: The prohibition of inhuman or degrading treatment
- Article 5: The right to liberty and security
- Article 6: In respect of a person's civil rights and obligations, the right to a fair and public hearing
- Article 8: The right to respect for private and family life, home and correspondence
- Article 10: The right to freedom of expression
- Article 13: The right to an effective remedy
- Article 14: Non-discrimination in the enjoyment of rights

This is not an exhaustive list. However, it identifies the key rights designed to ensure that vulnerable people within the health and social care system are treated in a dignified and human rights compliant way.

The table later in this chapter maps the findings of the investigation with the relevant articles of the European Convention. Despite Dunmurry Manor and the RQIA being aware of the serious causes for concern, little was done to address them within a reasonable timeframe. This falls short of the expectations of public authorities to be proactive in protecting and promoting the rights of some of the most vulnerable older people in their care.

The European Convention, as interpreted and applied by the European Court of Human Rights and by the United Kingdom's courts, recognises that public authorities have a duty to be proactive when they are aware that there is a vulnerable person who is, in some way, in the care of the State[9]. The obligations of the United Kingdom under the European Convention on Human Rights will not be affected by its departure from the European Union as the Convention falls within the remit of the Council of Europe. The United Kingdom will remain a member of the Council of Europe post Brexit.

This is a heightened duty on public authorities where the person is vulnerable and lacks the ability to advocate or defend themselves. The residents in Dunmurry Manor are clearly vulnerable because of lack of capacity, physical disability or poor mental health. The findings of this investigation identify that the RAs involved were aware of the low standard of care and of the repeated instances of physical and sexual assault in Dunmurry Manor. Furthermore, there was a systemic failure in Dunmurry Manor and its parent company, Runwood Homes Ltd (Runwood), to respond to a significant number of concerns identified by staff, families of residents, HSC Trusts and RQIA inspections.

More widely, there was a lack of appropriate response by statutory agencies to the concerns over the quality of the provision in Dunmurry Manor. This represents a failure to act to protect the basic human rights of residents and their families. Residents were in the care of the state. The state failed to care for them by its failure to respond to identified and serious cases of mistreatment. The safeguarding theme of this report identifies instances of failure to meet the requirements of the European Convention on Human Rights. For example:

- The failure to report 'notifiable events'
- Confusion over the use of the revised 2015 Policy
- Incomplete recording of safeguarding instances
- Medication errors
- Examples of residents being treated in an inhuman or degrading way

All of these provide strong evidence that the rights of residents were not being protected, let alone promoted.

There are many examples in the evidence of a failure to respond and prevent breaches of Article 3 of the European Convention – the right not to be subjected to inhuman and degrading treatment, and in some instances the article 2 right to have life protected. Both are absolute rights and do not allow any derogation. As noted above, these are positive duties and where, as in the case of RQIA and Dunmurry Manor, the state is aware, there is a clear duty to act.

The evidence submitted to the investigation provides examples of failures to respond to human rights violations. Abuse and neglect are inhuman and degrading and can be a threat to life. The findings identify evidence of ambulant males sexually and physically attacking female residents, but no clear evidence of an appropriate and effective response by the RAs. There is evidence that some residents were able to leave the home unsupervised and unnoticed. This potentially created a risk to life and to personal safety. Evidence of medication audits by the pharmaceutical provider was provided. Despite this, the number of medication errors identified is disturbing and, in some cases, inhuman or degrading. The concerns expressed by HSC Trust officials on record-keeping, lead to inhuman or degrading treatment, or in extreme cases to a threat to life. Systems should be in place and followed; staff should be made aware through training, mentoring and development of the importance of these in ensuring that the human rights of residents are recognised and protected.

The regime at Dunmurry Manor raises concerns about residents' right to liberty and security. To deprive a person of their liberty without appropriate legal safeguards is unlawful and a violation of their Article 5 right.

The Article 8 right to respect for private and family life, home and correspondence is a wide-ranging right. Although this is a qualified right (see Article 8(2)), there is nothing to suggest that the grounds for qualifying the right exist and no evidence that there was any attempt to justify actions taken on these grounds. All the findings on the safeguarding theme engage this right. Importantly the right embraces the idea of dignity and respect.

Regrettably, many of the residents in Dunmurry Manor and their families were denied the protection of this important Article 8 right. Evidence from witnesses indicates that dignity and respect, essential components of the right to private life, were lacking in the treatment of some residents in Dunmurry Manor.

Similarly, the evidence provided indicates there was little respect for

[9] See A v UK, X v Netherlands

residents' home life. As with all care homes, Dunmurry Manor was home for its residents. The extent to which residents could enjoy it was compromised by their treatment. There is evidence of failure to respect the home life of residents. The failure to put in place a robust process to protect female residents from sexual and physical abuse by ambulant males violated the right of residents to enjoy their home and their private life. Similarly, the evidence of lack of compassion in the delivery of care impedes the enjoyment of home and private life. Particularly disturbing, are concerns expressed by HSC Trust officials on record querying whether there was a culture of institutional abuse at Dunmurry Manor. The disclosed documents provided by HSC Trusts do not evidence a resolution to this query or any action taken to address the concerns.

Some former staff of Dunmurry Manor gave evidence that they were prevented from speaking out either to the RQIA or others, thereby violating their right to freedom of expression under Article 10. This had significant consequences for many residents whose poor treatment and neglect was never properly recorded or identified. In some cases reported to the Commissioner, family members were afraid to speak out for fear of retribution against their relatives. Others considered that they were not appropriately involved in discussions of their loved one's care.

The Article 6 right to a fair hearing and the Article 13 right to an effective remedy go beyond formal recourse to the courts, civil or criminal. They are about obtaining "justice" in its widest sense. The most effective remedy for the residents of Dunmurry Manor would be for the neglect and abuse to stop and for those responsible to be accountable. This would represent at least partial justice for those who experienced abuse and neglect and their families. The Commissioner finds that this did not happen. There was a failure by Dunmurry Manor and Runwood, to address concerns raised during inspections and by staff, family, the HSC Trusts and others. Similarly, the RQIA failed to promote and support the human rights of residents.

The RQIA does not investigate individual complaints. However, the cumulative effect of its inspection reports, individual representations and the concerns of the South Eastern HSC Trust should suggest to a public authority that it must respond with necessary urgency and address the problems without delay. The evidence points to the fact that this was not the response of the RQIA; it failed to ensure that residents had an effective remedy for the human rights violation they suffered in Dunmurry Manor.

Article 14 of the European Convention on Human Rights states:

> *"The enjoyment of the rights and freedoms set forth in this European Convention on Human Rights shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."*

Although age is not mentioned in this article, the reference to 'other status' includes discrimination based on age. This article is not free standing; it depends on there being a violation of one of the substantive rights. However, the article is engaged where the enjoyment of one of the substantive rights is violated because of, for example, age. The residents of Dunmurry Manor were older people whose human rights were violated. On the basis of the evidence, it is reasonable to assume that the treatment they experienced was discriminatory and ageist and thus a violation of this article.

The table below maps the findings of the investigation with the articles of the European Convention engaged.

Finding	**Article 2:** Right to Life	**Article 3:** Freedom from Torture and inhuman and degrading treatment	**Article 5:** Right to Liberty and Security	**Article 6:** Right to a Fair Trial	**Article 8:** Respect for your private and family life, home and correspondence	**Article 14:** Protection from Discrimination in respect of these rights and freedoms
SG 1	✓	✓		✓	✓	✓
SG2		✓		✓	✓	✓
SG3	✓	✓		✓	✓	✓
SG4	✓					✓
SG5					✓	✓
SG6				✓	✓	
SG7		✓			✓	✓
SG8			✓		✓	✓
SG9				✓	✓	✓
SG10		✓			✓	✓
SG11	✓	✓			✓	✓
SG12					✓	✓
SG13		✓			✓	✓

Regional Contract and the Host HSC Trust

HSC Trusts regularly organise placements when an older person is assessed as needing residential or nursing care. Where this is the case, the HSC Trust enters into a contract with the independent provider. This contract is referred to as the Regional Contract and it sets out general and specific terms and conditions. Amongst other things, these conditions require that nursing home providers are registered with the RQIA and that they comply with The Nursing Home Regulations (Northern Ireland) 2005, Care Standards for Nursing Homes 2015 and any other subsequent and/or relevant legislation. If the provider fails to deliver the service to a standard which is in compliance with the terms and conditions then the HSC Trust should regard this as unsatisfactory performance.

The HSC Trust has a series of mechanisms within the contract which they can use to bring about compliance with the standards, these include progressing to a reduction or refund in fees paid. While evidence was provided that issues with compliance within Dunmurry Manor had been flagged with the contracts division of the South Eastern HSC Trust, there was no evidence that the South Eastern HSC Trust had made effective use of the mechanisms within the regional contract to bring about compliance. The South Eastern HSC Trust acts as the host Trust for residents within Dunmurry Manor because it is located within the South Eastern HSC Trust region. As the host Trust, the South Eastern HSC Trust has an important lead role in overseeing the home.

Reporting an adult in need of protection to the HSC Trust

The investigation identified an apparent lack of clarity over what is an adult safeguarding issue and what is a *"quality monitoring"* incident. The threshold for identifying a possible adult at risk of harm and in need of protection should not be too high. It is unclear from the policy what the threshold is for a care provider to report concerns to the HSC Trust.

The policy states,

> *If there is a clear and immediate risk of harm or a crime is alleged or suspected the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.*
>
> *However in most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust, for a professional assessment.*[10]

The investigation disclosed evidence that there was a clear and immediate risk of harm and in some cases a possible crime. However, contrary to the 2015 policy these concerns were not always reported. The second paragraph is unclear as to when an emerging safeguarding concern falling short of an immediate risk should be referred to the HSC Trust. What is the significance of the word 'normally' in that paragraph? In what circumstances would a care provider consider not reporting an event to the HSC Trust? Good practice requires that where there is a reasonable cause to suspect that a person is an adult in need of protection, as defined in the policy, a report must be made to the HSC Trust. There should be no discretion on the part of the care home. The emphasis should be on having a reasonable cause to suspect; the standard of proof required to initiate a referral should be below the civil standard of balance of probabilities.

The HSC Trust would then decide on whether the adult is at risk and in need of protection and, if so, what the appropriate response should be. It is unacceptable that where there is a reasonable cause to suspect that there is an adult in need of protection, care providers should be able to categorise the behaviour as a "quality monitoring" incident rather than safeguarding. To tolerate this weakens the impact of the policy and leads to a lack of consistency across care providers. It also leaves adults who may be at risk in a potentially dangerous environment. A clear duty to report must be in place once there is a reasonable cause to suspect that the person may be an adult in need of protection.

The 2015 policy has much to commend it. However, several weaknesses were identified during the investigation.

The policy is not underpinned by a legislative framework. There is much debate on the desirability or otherwise of statutory safeguarding. Much of the discussion on the different approaches in England, Scotland and Wales centres on the extent of any legislative power, such as powers of entry and removal. These three nations adopt different approaches. However, all three recognise that a single organisation should have a statutory duty to make enquiries when they are made aware that there is a reasonable cause to suspect that an adult in need of protection is under their care.

The introduction of such a duty in Northern Ireland would require the HSC Trusts to make enquiries; this would address the dissipation of responsibility to respond under the policy that is apparent from the investigation. The threshold of reasonable cause to suspect would be met in most of the cases reviewed. There should have been no discussion on whether it was quality monitoring or safeguarding; the possible accountability of the perpetrator should not be an issue. The duty to make enquiries is proportionate and does not compromise the autonomy of the person. It does, however, ensure that all cases are considered, and decisions are made at HSC Trust level on action to be taken. It also requires duties on other public authorities and independent providers to report cases to the HSC Trusts when there is a reasonable cause to suspect that there is an adult at risk of harm and in need of protection. The policy would need to be revised in the light of these changes.

The introduction of a duty to make enquiries brings adult safeguarding into line with child protection in Northern Ireland. Article 66, The Children (Northern Ireland) Order 1995, imposes a similar obligation on authorities where a child is suffering or likely to suffer significant harm. The imposition of a similar duty in relation to adults would not risk treating adults as children. It is a duty to make enquiries and to decide what if any action should be taken. At this point, any action taken must be justified under general rules of consent or the Mental Capacity Act (Northern Ireland) 2016. Whether any further powers of entry or removal are required is a separate debate.

[10] ASG Policy 2015, page 32 https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf

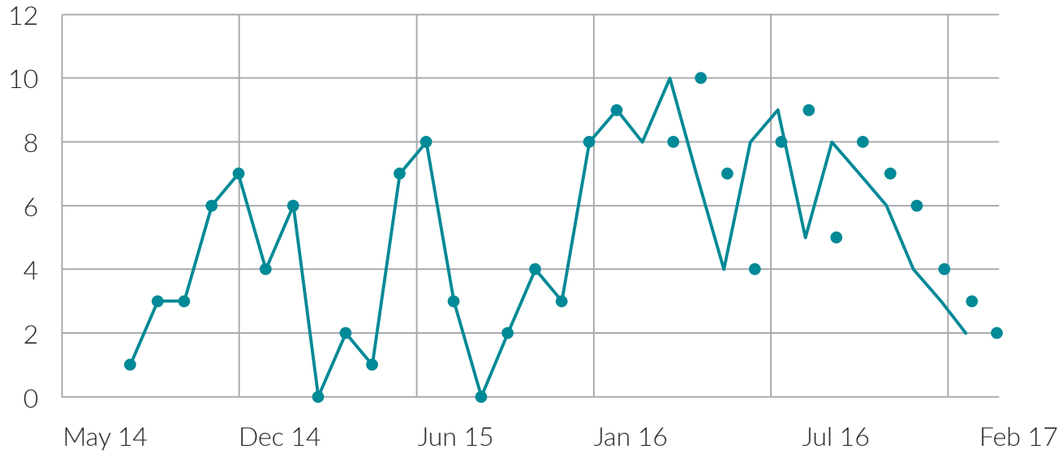
Mental Capacity

The investigation identified cases of ambulant males who lacked relevant mental capacity physically and sexually assaulting some female residents. Although there is an issue about the criminal liability of a person lacking capacity and questions as to the appropriateness of the placement arise, those who experience such behaviour are adults in need of protection. Such occurrences should be notified to the HSC Trust. However, it is essential that all incidents of this nature must be referred to the HSC Trust by the care provider as they involve an adult in need of protection. It is the responsibility of the HSC Trust to decide what the appropriate and proportionate response may be. This may involve referring the case to the Adult Protection Gateway Service or the PSNI, but not always. The unlikely criminal or civil liability of the perpetrator does not alter that fact, although it will affect the nature of the response.

CCTV

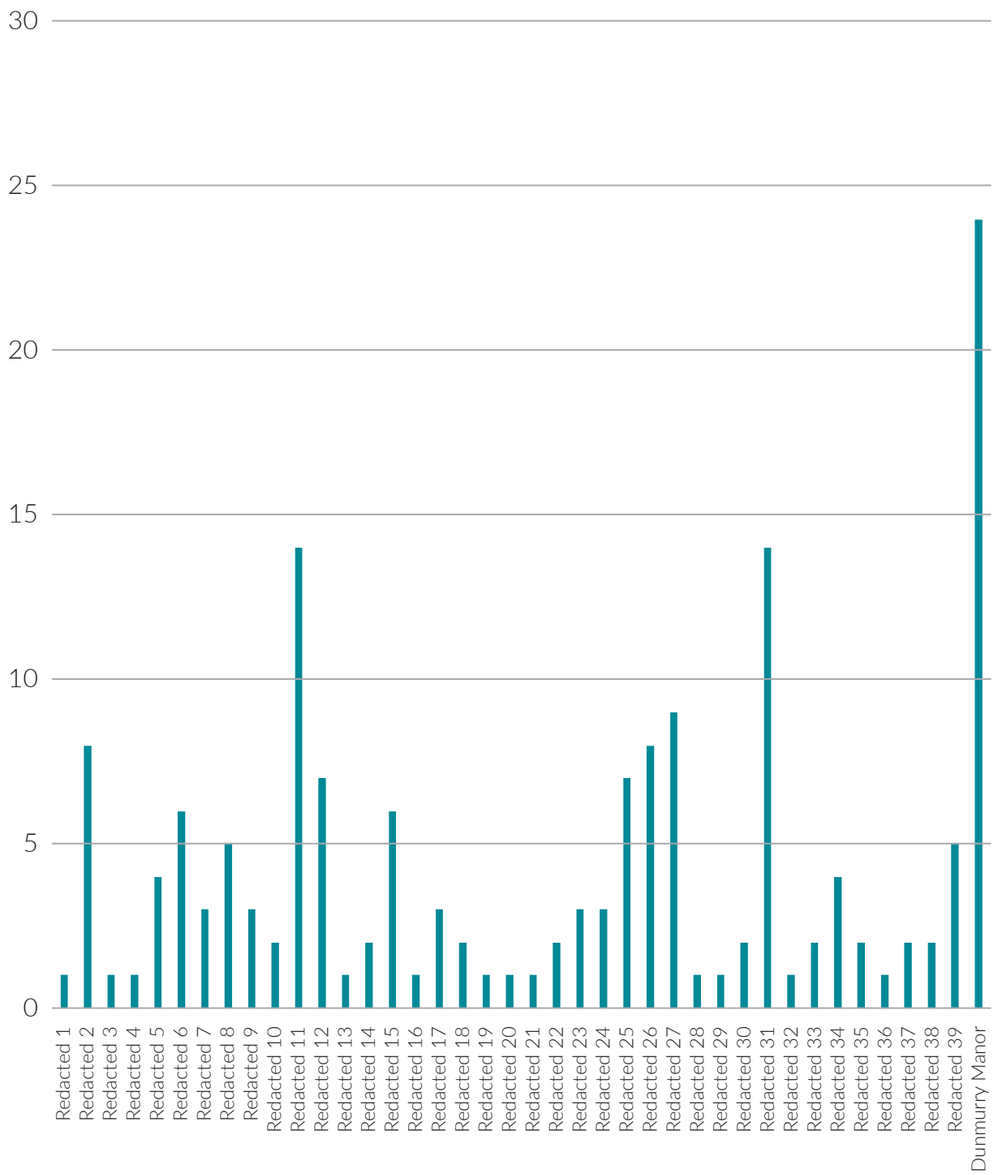
The question arose during the investigation as to whether the use of CCTV would have prevented the abuse and neglect. The Commissioner recognises that the use of, in particular, covert CCTV is controversial and complex. It cannot be used as an alternative to proper staffing levels in care homes. In some circumstances its use is justifiable. However, there are human rights and data protection issues that need to be considered. It is also essential to ensure that any footage is of sufficient probative value to justify its use. Comprehensive guidance is needed on when and how to use CCTV.

Number of safeguarding Incidents in Evidence - By Month



An example of a three-month snapshot of adult-safeguarding investigations in Dunmurry Manor, in comparison to other homes in the South Eastern HSC Trust, can be seen in the Trust's quarterly governance report of quality issues. This snapshot is taken from the period of 1 January 2016 - 31st March 2016.

Number of Vulnerable Adult Referrals - 01/01/2016 to 31/03/2016



Findings of the investigation in relation to Safeguarding and Human Rights

The table below is a summary of the investigation findings in relation to safeguarding and human rights in Dunmurry Manor:

	Theme 1: Safeguarding and Human Rights
SG1	A pattern of evidence of consistent failure within Dunmurry Manor to report significant numbers of incidents ("notifiable events") to the RQIA and to the Trust, in line with their requirements under Regulation 30 (of the Nursing Homes Regulations (Northern Ireland) 2005).
SG2	Despite evidence of ambulant males physical and sexual assaults on a number of female residents, there was a lack of a clear coherent policy to manage these risks over prolonged periods of time.
SG3	Confusion over the interpretation and implementation of the 2015 revised Adult Safeguarding Policy – a lack of consistency across Trusts of what constitutes a "quality monitoring" incident and what constitutes an "adult safeguarding issue", particularly where there are issues around capacity.
SG4	Examples of physical security issues with residents able to leave Dunmurry Manor unsupervised and unnoticed.
SG5	Daily observations and care charts completed from memory rather than contemporaneously.
SG6	A confusing variety of documentation in use for safeguarding, incidents, accidents and complaints – documentation frequently not signed or dated; date of incident marked at a future date; incomplete – e.g. no details of either the vulnerable adult or the alleged perpetrator; no GP follow-up or record of physical check or body map completed.
SG7	Lack of evidence to show that Dunmurry Manor implemented 15 minute monitoring (close observation) checks following reported safeguarding incidents.
SG8	Evidence from residents' families[11] raising a fear of other residents entering their rooms at night and an unauthorised practice, by one staff member, of locking residents into their rooms from the outside.

[11] Provided to the RAs

	Theme 1: Safeguarding and Human Rights
SG9	Incomplete records hampering thorough and comprehensive investigations into reported safeguarding issues and concerns.
SG10	Medication errors / omissions leading to spikes in the number of safeguarding incidents for residents (See also Theme 3).
SG11	Inadequate response by HSC Trusts to concerns raised by officials of potential institutional abuse in Dunmurry Manor.
SG12	Evidence of delays by Dunmurry Manor staff in calling the Ambulance Service and / or GPs despite serious concerns or incidents having occurred leading to a loss of dignity and a violation of the residents' human rights.
SG13	Consistent examples reported by residents' families, HSC Trusts and workers / former staff of inhuman or degrading treatment.

Recommendations: Safeguarding And Human Rights

R1: An Adult Safeguarding Bill for Northern Ireland should be introduced without delay. Older People in Northern Ireland must enjoy the same rights and protections as their counterparts in other parts of the United Kingdom.[12] 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.

R2: The Safeguarding Bill should clearly define the duties and powers on all statutory, community, voluntary and independent sector representatives working with older people. In addition, under the proposed Adult Safeguarding Bill, there should be a clear duty to report to the HSC Trust when there is reasonable cause to suspect that there is an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries.

R3: All staff in care settings, commissioners of care, social care workers, and regulators must receive training on the implications of human rights for their work. 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.

R4: Practitioners must be trained to report concerns about care and treatment in a human rights context.

R5: Policies and procedures relating to the care of older people should identify how they meet the duty to be compatible with the European Convention on Human Rights.

R6: The registration and inspection process must ensure that care providers comply with the legal obligations imposed on them in terms of human rights. 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.)

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.

[12] They should have the same rights and protections as provided to children, another recognised vulnerable group

4.2. Care And Treatment

Conclusions: Care and Treatment

The evidence gathered during the investigation supports the following conclusions in terms of the care and treatment experienced at Dunmurry Manor:

- Experiences of poor care and treatment were a common feature of witness evidence
- Experiences of poor care and treatment were a common feature of incident reporting to relevant HSC Trusts
- Families felt they had to move their relative to another home due to poor care
- The numbers of incidents reported to the investigation team exceeded those on record with the HSC Trusts and the RQIA
- Families consistently felt excluded from decision making involving their loved ones
- Families, agency staff, former Dunmuury Manor staff and HSC Trust staff all had concerns and made efforts to highlight them to either management in Dunmurry Manor, to Runwood senior management and / or to the RQIA

The fundamentals of good nursing and social care are the aspects of care and compassion which we would wish for ourselves or those close to us. We all expect care to be safe and effective, delivered by caring and compassionate professionals who have up to date knowledge and skills. Good care must focus on a number of important factors including attention to personal hygiene, ensuring people have adequate food and fluids and that their continence needs are met. These are the issues most frequently raised by families and staff when they feel care has fallen short of what they expect.

Legislation and Standards

The Nursing Homes Regulations (Northern Ireland) 2005 and Standards identify the following standards that care homes must follow:

15(1)(a) Not to provide accommodation to a patient unless, *'the needs of the patient have been assessed by a suitably qualified or suitably trained person'*, and *'appropriate consultation regarding the assessment with the patient or a representative'*.

12(1)(a) Registered Person must ensure the service provided to patients meets their individual needs, reflects current best practice, and where necessary is provided by means of appropriate equipment.

Schedule 3, 3(o), records to be kept in a nursing home in respect of each patient including records of falls, pressure ulcers, and treatment provided.

12(4)(a) Registered Person shall ensure that food and fluids are *'provided in adequate quantities and at appropriate intervals'*. (b) Food and fluids be *'properly prepared, wholesome and nutritious and meets their nutritional requirements'*, are suitable, provide choice and varied at suitable intervals. Schedule 4(13), *'Records of the food provided for patients in sufficient detail to enable any person inspecting the record to determine whether the diet is satisfactory.'* 18(2)(g) provide *'adequate facilities for the preparation and storage of food.'*

Standard 4 Each resident's health, personal and social care needs are set out in an individual care plan which provides the basis of the care to be delivered. The initial care plan should be in place within 24 hours from assessment.

Standard 8 Records be maintained for each resident detailing their personal care and support, changes in the resident's needs and incidents. When no recordable events occur, there should be an entry at least weekly for each resident to confirm that this is the case.

Standard 23 Prevention of pressure damage, 'clear and documented processes for the prevention, detection and treatment of pressure damage or ulcers'.

Pressure damage risk assessments and body mapping are carried out for all residents where possible prior to admission and at the latest on admission to the home as well as on leaving for any transfer to hospital and subsequent re-admission. Where a resident is assessed as at risk of pressure damage, a documented pressure damage prevention and treatment programme is drawn up and agreed with relevant professionals and entered into the care plan. A validated pressure damage grading tool is used to screen residents who have skin damage and an appropriate treatment plan implemented, and incidents of pressure damage and treatment recorded in records. Pressure sores assessed as Grade 2 or above are reported to the RQIA and the HSC Trusts in line with guidance and protocols.

The following two anonymised case studies outline the lived experience of care and treatment in Dunmurry Manor:

Resident C

Resident C (Res C) was 83 years old and living with dementia when they suffered a severe fall whilst living in supported accommodation. Res C was admitted to Dunmurry Manor on discharge from hospital. The injuries sustained from the fall led to Res C having reduced mobility with a significant decrease in the use of their hands.

Res C weighed 15 stone when entering Dunmurry Manor. According to their family, Res C weighed between 5-6 stone when they died five months later.

The family complained about their loved one's rapid weight loss and expressed concern that this was due to Res C not being assisted to eat. They said that food was frequently left on trays beside Res C, uneaten and that food was frequently cold even before it was provided to Res C. For medical reasons, Res C was supposed to have a diet high in fat and calories but the family said it was not clear if this was provided. The family believe that, quite often, Res C was not offered cups of tea as this required someone to sit and help Res C drink through a straw. Res C became very dehydrated and sick and was returned to hospital due to these symptoms three times in 3-4 months.

The family said that some of Res C's meals contained foods which Res C could not eat or which Res C did not like, but that resident preferences were not taken into account. They felt that staff did not have enough time to sit with Res C or to notice when foods were not eaten. Res C's family felt Res C was forgotten about because Res C was bedbound and in their own room all the time.

Res C needed regular support with bowel evacuation but it was not clear to the family if this procedure was being carried out. The family say that none of the staff appeared to know what medication Res C was supposed to be receiving. The family observed that the nursing staff seemed busy and often the medication round was delayed. Res C required eye cream to be applied for an infection, but three days later when Res C's relative asked for the tube of cream so that they could apply it, the tube was unopened. The relative realised Res C had never had any treatment for the eye infection.

Res C's relative felt like the staff became frustrated with them for asking questions and raising complaints. Res C's relative told the investigation that it felt like "here they come again". They explained that there was never any meaningful response when they raised concerns.

Resident D

Resident D (Res D) was aged 89 and had gone through an assessment of their needs in hospital and was diagnosed as living with dementia. The family was informed that Res D could no longer live independently and had been assessed as needing residential care. Res D was placed in Dunmurry Manor.

Res D's family received a call at 3.30pm from the home to say Res D had been found sitting on the floor in their room that morning. Res D's family visited to check they were well and settled for the evening. The relatives found Res D alone in the room with the door shut. There was vomit on Res D's clothing and Res D appeared very unwell. Res D's family asked staff to call an ambulance. Staff questioned if this was necessary. When Res D's family started to pack a bag for hospital they realised the drawers were empty and they had to search for clothes. When admitted to hospital, Res D was diagnosed with kidney failure, E Coli infection, septicemia and pneumonia.

When Res D's family asked about the circumstances leading up to the discovery of their family member on the floor, they were given a number of contradictory accounts of the time at which Res D had fallen and the condition in which Res D was found. A staff member stated she had been keeping a close eye to Res D due to health concerns but this is not documented anywhere. Family discovered they were informed nine hours after Res D was found.

Res D's family had raised concerns previously about personal hygiene, soiled bed clothes and poor continence care. The family carried out a deep clean of Res D's room themselves with their own cleaning equipment on one occasion as it was so poor. They also left a urine sample on the toilet cistern to see how long it would go unnoticed. The sample remained there for days.

Res D's family was repeatedly asked to pick up prescriptions due to low staffing. They also brought food in for Res D regularly as they were concerned Res D missed out during mealtimes.

Care Planning

Planning and implementing care is an essential element of nursing and social care. Assessment of residents on admission should be carried out using recognised tools such as the Braden skin assessment tool or the Malnutrition Universal Screening Tool (MUST). These assessments will determine the immediate priorities for that resident and whether referral is required to another healthcare professional.

Following assessment, care needs should be planned and interventions agreed and communicated effectively to the care team. Effective evaluation of care requires the nurse to analyse the residents health status to determine whether the resident's condition is stable, has deteriorated or improved and if the planned care is appropriate.

Evidence given to the Commissioner supports the view that there was poor care planning and management of residents' changing needs.

- Agency and new staff reported problems with documentation. *"They didn't seem to have time to do care plans... when looking at patients' notes there was a total lack of care plans."* Another staff member said they were, *"terribly out of date when I started...we had to start right back at the beginning and get everything up to scratch again."*
- *"Care plans are horrendous to read... so for an agency person only there for two nights to be able to go in and read what a residents needs are would be very hard"* stated another agency nurse.
- In January 2017 South Eastern HSC Trust staff were concerned when they noted that residents were losing weight. They requested to see the MUST risk assessments. However no resident in Dunmurry Manor had an assessment nor could records of special diets be located. The South Eastern HSC Trust's nutritionist and speech and language therapists were then urgently brought in to carry out training and supervision in an effort to improve the residents' nutritional status. The 4th January 2017 RQIA Inspection Report mentions that no action had been taken with a resident who had suffered from a substantial weight loss, with no evidence that they had been referred to the relevant health professionals and that the risk assessment and care plan reflected their changing needs.
- The South Eastern HSC Trust placed a support team in Dunmurry Manor later in 2016 to allow enhanced monitoring and support. One senior nurse reported being frustrated by the poor care planning and advice not being acted on by Dunmurry Manor. She went on to say, *"the amount of paper work and follow up the Trust has to do has been incredible, it got us frustrated that more was not being done by the Trust and RQIA."* Another trust member of staff advised that she had asked repeatedly to view care plans. In direct contravention of Standards four and eight. She said they were *"not available until multiple requests were made to Dunmurry Manor... had to hound them... they were very basic care plans."*

- The South Eastern HSC Trust again facilitated training in January 2017. One facilitator wrote a behavioural management care plan and showed staff what care planning was required in respect of one resident, however it was ignored. The HSC Trust representative went on to say, *"Dunmurry Manor has taken up a lot of my time. Some of the things I have done for Dunmurry Manor I wouldn't do for other homes."*
- A social worker reported concerns about care planning and the use of cot sides, especially as there were inappropriate risk assessments being done regarding cot sides. This staff member was so concerned he contacted RQIA.
- Another HSC Trust manager advised that there were concerns from the start regarding documentation. They conducted audits, agreed action plans with Dunmurry Manor managers and had joint meetings with RQIA to raise concerns.
- Relatives also echoed their concerns regarding the lack of care planning and consultation with them on the residents' care. A son advised that a *"care plan was not produced until two months after his father was admitted"*. This was produced in response to a complaint he had raised regarding his father's personal care and lack of showering.
- Another resident's husband stated ... *"doing a care plan was a waste of time as it was never implemented. Dunmurry Manor just do what they want to do or what they have time to do."*

Nurses and social care staff have a professional responsibility to ensure all healthcare records provide an accurate account of nursing and social activities and they are kept up to date and provide a vital communication within the nursing team. The Nursing and Midwifery Council Professional Code of Practice gives clear guidance on this and states:

> *"This includes but is not limited to patient records. It includes all records that are relevant to your scope of practice.*
>
> *To achieve this, you must:*
>
> - *Complete all records at the time or as soon as possible after an event, recording if the notes are written sometime after the event*
> - *Identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*
> - *Complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
> - *Attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*
> - *Take all steps to make sure that all records are kept securely*
> - *Collect, treat and store all data and research findings appropriately."*

The Northern Ireland Social Care Council's (NISCC) Standards of Conduct and Practice for Social Care Workers make clear that understanding the main duties and responsibilities of your own role includes *"Keeping records that are up to date, complete, accurate and legible."* Maintaining the trust of service users will include *"holding, using and storing records in line with organisational procedures and data protection requirements."*[13]

Evidence of poor and inadequate care planning, including incomplete resident care records, retrospective updating of care records, families not involved in care planning and poor quality of information in care plans in Dunmurry Manor was noted by many of those interviewed. Evidence was provided, as summarised above, that concerns were communicated to HSC Trust staff and to the RQIA. However, there is no evidence that the action taken by either RA led to improvement in Dunmurry Manor. Issues which were first raised in 2014 formed the basis of a safeguarding investigation in late 2016.

Personal Care

While a number of family members of residents interviewed stated that generally their relatives' personal care was good, there were significantly more who reported concerns with many aspects of the care delivered. Some relatives acknowledged that it can be challenging for staff to care for those with dementia as they often refuse care, particularly showering and toileting. Relatives believed that the staff lacked adequate dementia training that would assist them to work better with their loved ones and enable residents to become more settled and willing to engage with staff.

The case studies in this chapter demonstrate the extreme effects of poor care for those residents. However many other families gave the Commissioner evidence of the sub-standard care provided to their relatives:

- A relative reported that her loved one's *"personal care was virtually non-existent"* while another reported that they take their father to their own home to get him washed properly.
- One relative had serious concerns over the two-month period her relative was a resident in Dunmurry Manor. This resident always took a pride in their appearance but the level of personal care offered fell significantly short of what the family expected. The family had to clean the resident's teeth each time they visited and reported that her *"hands had not seen water as her nails were very dirty. We could see her face wasn't washed and hair not combed."* When this relative decided to take off her mother's bed socks she was *"appalled"* at the condition of her feet. *"On the right foot encrusted pus was running down her toe... it was infected, and obviously not just from the previous day. Some was dried between her second and first toe. Staff either hadn't noticed or weren't changing her socks. If she had been showered... the pus would have been washed out. Staff in Dunmurry Manor said they had no knowledge of it."*
- One Care Manager advised that when he reviewed a resident's care he discovered that he had only had two showers within a six week period. He subsequently

[13] Northern Ireland Social Care Council, 'Standards of Conduct and Practice for Social Care Workers', https://niscc.info/storage/resources/web_optimised_91739_niscc_social_care_workers_book_navy__pink.pdf

had to issue quality monitoring forms to Dunmurry Manor advising them that he was monitoring this aspect of care for the resident. The Care Manager also reported his concerns about personal care in Dunmurry Manor to the RQIA inspector.

- A former employee also reported *"residents were not routinely washed at night… I was told I was taking too long and to just tick the sheet that this had been done."* She went on to say… *"Residents were never hoisted - too much hard work"*.

Many studies have demonstrated the impact of high quality nursing care on patient outcomes and even mortality. Reducing the skill mix and numbers of registered nurses in a health and social care facility can have a detrimental impact on the patient's experience and outcome.

Key to the delivery of care is that it should be patient or resident focused and based on their assessed needs and identification of risks. Nurses need to be aware and diligent about managing risks and ensuring steps are taken to mitigate those patient centred risks such as the risk of falling or malnutrition. Skilled nursing is essential in meeting the anticipatory care needs for those who are unable to express their specific concerns or lack capacity. This requires the ability to recognise when a patient is in pain or distress and to take appropriate action.

In addition, compassion is an essential aspect of good nursing care and can make a significant difference to the overall experience of patients and their families[14]. The focus on compassion has received much debate in recent years with the intense media attention on examples of poor and even cruel care such as that reported in Winterbourne View care home. The poor standards of care and compassion in these examples have rightly caused public outrage as well as within the healthcare professions.

One of the impacts of these publicised episodes is a rise in families considering the installation of covert cameras in their relatives' rooms care home, in order to give them some peace of mind and ensure adequate care is being delivered (as previously considered in Theme 1). It is sad that families feel they have to take such drastic steps.[15] Families of some residents of Dunmurry Manor residents have recently commenced a campaign promoting the use of CCTV in care homes.

Nursing and social care staff play a pivotal role in communicating effectively with residents and their families. They are generally the first point of contact and are at the heart of the communication process. They receive confidential information which must be handled sensitively and are expected to deal effectively with any concerns or complaints made about the service being offered.

There is a reasonable expectation that good nursing and social care should be at the centre of all healthcare experiences and can be conveyed even through the smallest of actions and interactions: holding a hand when someone is in distress, demonstrating empathy and understanding when someone is confused and showing compassion and care to someone.

The care at Dunmurry Manor, as evidenced by the families' and former staff experiences, could not be characterised as good practice.

[14] Transforming Care: A National Response to Winterbourne View Hospital: Department of Health Review Final Report (December 2011).

[15] Cross reference to CCTV section in Theme 1 - Safeguarding

The evidence given to the investigation describes a chaotic environment. The nursing staff, many of whom were temporary agency staff, working single shifts and never returning and where staff were under immense pressure to meet the complex needs of a large number of residents living with dementia.

Eating and Drinking

The provision of adequate nutrition and hydration for older people is essential to sustain life, good health and reduce the risks of malnutrition and dehydration. Planning is key to ensuring older people get the correct nutrition based on a nutritional needs assessment. For some it may require a special diet and include prescribed nutritional supplements, while for others their preferences, perhaps based on religious and cultural backgrounds, must be taken into account.

Good care needs to focus not only on the quality of food, but also the availability of it, including the frequency and timing of meals and also on the level of assistance which older people may require to enable them to eat and drink adequately. For example, the seating and tables available in a dining area, the need for adapted or special cutlery, the support or encouragement required to assist the older person and time to allow them to enjoy a meal.

Meal times are periods in the day which residents look forward to. It is an opportunity to meet with others for social interaction and helps to define the periods within the day, morning, afternoon and evening. The appetising smells and sights of food properly cooked and presented is important for older people who may have reduced appetites and need encouragement to eat and drink.

Many of those interviewed were complimentary regarding the quality of food offered to residents. They commented on the variety of food, snacks and home-made tray bakes available.

However, this was not the experience of all those interviewed. There were many concerns raised by relatives regarding the food experience for residents. Relatives reported a lack of support for those residents who required assistance with eating and drinking and the serious impact this had on their health. A number of relatives reported serious weight loss and dehydration due to staff not ensuring residents were eating and drinking adequate quantities of food and fluids. A number of these failures led to emergency admissions to hospital when residents became dehydrated and in others when weight loss was so severe it led to other complications such as tissue breakdown and pressure ulcers.

The Commissioner was informed by a number of families and former staff of issues and concerns about eating and nutritional needs being met:

- A daughter was concerned that staff did not notice her mother losing a stone in weight in a matter of days. Another relative commented about his father's weight loss… *"It was alarming that staff did not notice the severe weight loss."*
- A number of families told the Commissioner that they had to visit at meal times to ensure

their relative was fed. One stated, *"He needed to be fed and there wasn't always a member of staff to feed him. The family deliberately visited at meal times to check what was happening and make sure he got fed or to feed him. There wasn't enough to eat or drink ...he became dehydrated and lost stones in weight."*

- As a result this family decided to transfer their father to another nearby nursing home. *"He has put some weight back on after going to [another] Care Home. Size medium clothes were hanging off him but are now tight. He now interacts with staff and residents...in Dunmurry Manor he was like a skeleton. No interaction ...never smiled."*
- Another relative felt the pressure to visit every day to feed her father. *"I used to go in every night to visit dad in Dunmurry Manor but now in [another] Care Home it is three times a week and he's now happier. If family hadn't been there dad would be dead."*
- Another son reported his father lost six stone in a year in Dunmurry Manor, while another son had no choice but to move his father to a different home due to his concerns. He stated, *"Father was admitted to hospital on four occasions due to dehydration... after August he was so bad they couldn't find a vein. A hospital doctor said "this is a shame and disgrace that a man should be in this situation"... with him going into A and E so many times surely alarm bells should have been ringing. It just felt like no one was interested let's be honest. [Identified staff member] went down to see him and he was lying in congealed vomit with the doors closed. The door was always closed. He had vomit down him and was that weak he couldn't turn to press the buzzer. His wife went ballistic... saw the care worker about it. You know what it was like... to be blunt he was left to die. Does anyone give a damn, does anyone care? For a facility that was there for nursing and care and neither was there. That is what we were living with."*
- Staff also raised concerns regarding residents losing weight. *"Weight loss is a concern in the home. Just because you can lift a spoon doesn't mean you don't need assistance. Bedbound residents are a concern... they may not get the help they need."*
- One staff member voiced concerns regarding the lack of fluids for residents and the number who were developing urinary tract infections. He tried to take action but felt he was not listened to and subsequently he contacted RQIA to express his concerns regarding the poor quality of care. He stated, *"no matter what you said, you'd be better off talking to that wall...nothing followed up on, or it was a case of I'll get back to you, just trying to palm you off. I got to the stage where I thought what's the point? No one listens."*

Continence Care and Toileting

Many residents in long term care are likely to have some degree of urinary incontinence or dysfunction, however, urinary incontinence in this setting should not be viewed as inevitable. In the first instance, with good management it may be preventable. Incontinence is a symptom of underlying problems which with simple assessment and investigation, can be identified and treated. Even when a cure is not achievable, optimum methods of incontinence management can be attained and help alleviate embarrassment and discomfort for the older person as well as preventing pressure sores and infection.

Loss of bladder and bowel function can be very distressing for older people and their relatives. Excellent care is essential for the person with incontinence and it requires patience and understanding to ensure the preservation of dignity and self-esteem. It can be particularly distressing for the person living with incontinence, as well as their families to experience care which is substandard.

Many families reported significant issues in relation to their relatives' continence care and management. These issues were most frequently due to finding their relatives' continence care neglected and the neglect exacerbated by the poor quality of continence products being provided by Dunmurry Manor. Families provided testimony to the investigation about the poor management of their relatives' incontinence.

- Some families told the Commissioner that they often found their relatives lying in pools of urine, in bed or on their chair. One said *"father was often left soaking for hours."*
- Another reported finding her relative *"lying on a wet bed without a pad ... there was no toileting."*
- One daughter, who was concerned about her father's continence care was told by staff not to get involved in her father's personal care. She reported a shortage of continence pads and requested staff to stop using net pants as they were leaving marks on her father's skin. However she often found her father's *"pads soaking."*
- A son reported that on occasions there were not sufficient incontinence pads for his mother and as he walked past other residents' rooms *"it is clear their continence needs are not being met because of the smell."*
- Staff reported a tight control on the budget by Runwood particularly when it came to the purchase of continence products. One care team leader was told she had over spent one week by £10 and she could not have the pull up continence pants she had requested that week due to this minor over-spend. She commented that the products purchased were of the cheapest quality. One relative supported this view and told the Commissioner that he bought his own continence products for his mother due to this problem.
- Agency staff reported their concerns regarding continence care. There was *"no toileting regime... just put pads on them and that was it and the continence pads were cheap quality. Residents did not have a toileting regime- they were just put in pads end of...there was no toilet round conducted before tea."*

There appeared to be little attempt by staff to encourage toileting regimes for residents to try and promote good continence care. It appeared that it was easier just to put residents into pads or other incontinence products and then leave them for hours in soiled or soaked pads. Even when residents were admitted to Dunmurry Manor fully continent relatives reported that they soon became incontinent and this was very distressing for both residents and families. Families reported that this was a result of there not being adequate staff and equipment to safely assist with continence needs. The

evidence presented to the Commissioner demonstrated that continence care fell significantly below the standard expected in a care setting.

Skin Care / Tissue Viability

Skin care in older people is an important aspect of good nursing care. Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. Older people are more likely to develop pressure sores as skin naturally becomes thinner with age and this can be worsened by a more sedentary lifestyle and an inability to move and reposition the body.

They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time. Pressure ulcers can affect any part of the body that is put under pressure and are most commonly found on bony parts of the body, such as the heels, elbows, hips and base of the spine.

Older people are at greater risk of pressure ulcers especially if they have mobility problems and have skin that is more easily damaged through dehydration and other factors such as: being confined to bed with illness or after surgery; inability to move some or all of the body (paralysis); obesity; incontinence and certain medical conditions that affect blood supply such as diabetes, heart failure, multiple sclerosis and Parkinson's disease.

Good skin care or tissue viability is a specialty within nursing given its importance in ensuring skin integrity and wound management. A skin risk assessment, using a recognised skin assessment tool, for all residents on admission and "at risk" residents at regular intervals is vital in any care setting. Relatives and trust staff reported a number of skin care concerns to the Commissioner's team during the investigation.

- Two or three months after Dunmurry Manor opened, South Eastern HSC Trust staff recognised that Dunmurry Manor staff did not have up to date skills and knowledge in managing pressure ulcers. One HSC Trust senior manager stated: *"Their level of knowledge frightened me... I got the Tissue Viability Nurse to go through all the wounds, right pressure relieving mattresses, wanted back to basics, needed to know that everyone was being treated in the right way for tissue viability."*
- The HSC Trust continued to monitor the quality of skin care and offered advice and training on a regular basis from the Tissue Viability Nurse. She noted, *"if I went in to see someone's notes and saw they were not using the appropriate risk assessment tool, like not using Braden, I would have raised it as an issue, had training, talked to staff and signposted them".*
- Despite this guidance and support HSC Trust staff often found failings in respect of skin care. A Trust report details that a resident who was admitted for respite developed a Grade 4 pressure sore on his heel and when documentation was reviewed found, *"no pain assessment in place, incomplete documentation, no body map, no assessment and documentation was not person centred."*
- Even when a South Eastern HSC Trust tissue viability nurse visited to review residents with skin problems and had prescribed specific care this *"had not been appropriately implemented."*
- On other occasions HSC Trust staff noted: *"it was concerning that a resident did not have a care plan in relation to pressure sores when they had Grade 2 and Grade 4 pressure sores".*

Despite the fact that the South Eastern HSC Trust was aware of a lack of skin assessments for residents in Dunmurry Manor, evidence provided to the Commissioner demonstrated poor skin and tissue viability care in Dunmurry Manor. It is not clear from the evidence provided to the investigation what level of action was taken by senior officials within the South Eastern HSC Trust even when these serious concerns were highlighted.

Moving and Handling

Moving and handling is a key part of the working day in many environments[16], but is particularly important in a care setting where residents need assistance with carrying out their activities of daily living and where they are unable to move and reposition without assistance. If staff are unable to carry out tasks safely they can place themselves and others at risk of harm and injury. Poor moving and handling practice can lead to:

- Back pain and musculoskeletal disorders, which can lead to inability to work
- Moving and handling accidents which can injure both the person being moved and the employee
- Discomfort and a lack of dignity for the person being moved

Safe moving and handling practices are essential in all care settings with a workforce adequately trained and supervised and the provision of safe moving and handling equipment.

The Commissioner was provided with evidence that Dunmurry Manor operated unsafe moving and handling practices including inadequate assessments, training and lack of essential equipment.

Staff and families reported that some staff were not trained in the use of hoists for moving and handling residents and many suggested it was easier and quicker not to use a hoist. This unsafe practice placed both residents and staff in danger of injury and should have been identified as a key risk for the organisation.

- One HSC Trust email referred to an incident of a nurse insisting a resident should be lifted into bed by another employee when a care assistant had pointed out the hoist must be used. A HSC Trust Concerns Meeting references *"poor manual handling"* in the home.
- Another former staff member described a resident being lifted after a fall... *"the agency guy came in and basically, I think the woman was 97 at the time, just picked her up by the hand and under the arm like that and the residential manager told him to stop and went in and closed the door and helped him lift her."*
- Relatives also noted that staff were not using moving and handling equipment. A son of a resident noted, *"The equipment seemed good but there was no staff training on how to use it. Staff didn't use the hoist as they felt they weren't trained and lifted the person instead."*

[16] Royal College of Nursing, *Moving and Handling: Advice Guides*, https://www.rcn.org.uk/get-help/rcn-advice/moving-and-handling

- A staff member reported that while there were four hoists in the home only two of them were in working order. This was inadequate for the level of activity in Dunmurry Manor. Another said there was only one standing hoist in one unit... *"this ratio didn't seem right."*

The inadequate supply of moving and handling equipment led to unsafe practices with hoists reported as being faulty. This was unacceptable and demonstrated a total lack of regard for the health and safety of residents and staff.

Equipment

Staff require a wide range of equipment to carry out their roles in any care home setting. Kitchen staff need safe and reliable equipment to enable them to cook, domestic staff require tools to undertake their cleaning roles and responsibilities while the nursing and social care staff require a range of equipment to safely care for residents.

These may include monitoring equipment such as sphygmomanometers to carry out blood pressure monitoring, moving and handling equipment, pen torches to check a resident's pupil reactions, dressings, urinalysis testing equipment as well as basic items such as cleaning solutions. Safe and reliable equipment, which is checked and tested regularly, is essential to allow all staff to work in these settings.

Many staff from Dunmurry Manor and the South Eastern HSC Trust reported their frustration at the lack of equipment in the home and the length of time it took to get some items repaired.

- An observational report by a HSC Trust states that there were *"no commodes available for toileting... there is no provision of equipment to effectively manage ongoing care at night...there was limited equipment for moving and handling."*
- Another South Eastern HSC Trust communication to RQIA highlighted how the home had no spare catheters or bladder washouts. While a South Eastern HSC Trust meeting note refers to showers chairs being shared between units.
- A former employee referred to personal protective equipment to control infection like gloves and aprons as *"atrocious...all cheap...raised this with all managers...but better equipment was not provided."*
- A former manager described difficulties in ordering equipment through Runwood Head Office. *"I have asked for jugs and maintenance trolleys ... never turns up. Head Office declines. I put an order in for hats and tea towels ...six months down the line they still haven't* arrived. *No reason is given. I was told money had been spent on legionella and therefore they have no money to buy crockery."*
- Several staff reported that they often had to go and purchase items of equipment to enable them to do their job and they were never reimbursed. *"I didn't have access to pen torches, inadequate dressings, plasters, blood pressure monitors. I don't know but even the most basic of equipment. I bought my own BP monitor. I reported it but was told there wasn't enough money...where do you go with that then?"* The same member of staff went on to say, *"you were expected to make an incontinence pad last and that was ridiculous, we didn't have sufficient numbers, we ran out of wipes as well. Girls were just using facecloths to do the entire person. For infection control purposes that's not ok. Not enough dressings too."*
- Another member of staff advised that they had to buy urine analysis sticks with their own money.
- Frequently staff reported going to the local supermarket to buy cleaning products, wipes and tissues for residents.

Many staff from Dunmurry Manor and the South Eastern HSC Trust reported their frustration at the lack of equipment in the home and the length of time it took to get some items ordered and others repaired. It was totally unacceptable that staff had no option but to buy their own equipment as they could not get the company to get faulty equipment repaired or replaced. Kitchen staff could not get hats, which are essential health and safety measures for catering staff, for over six months. The poor quality, supply and control by the company on the purchase of incontinence products was a constant problem and was reported frequently to the Commissioner during this investigation. This was very concerning and must have contributed to the tissue viability issues which a number of residents experienced.

Management of Personal Property

An issue for most of the relatives, including those who did not have any issues regarding the care in Dunmurry Manor, was around residents' personal property going missing. This ranged from clothing being sent to the laundry and not being returned to more expensive possessions such as jewellery and money being lost.

Relatives could not understand how so many clothes went missing when they had spent time carefully labelling them. This was a recurrent theme with almost all relatives interviewed. Of particular frustration for them was the inadequate response from Runwood when they raised these issues. They just felt their complaints were never taken seriously.

- A daughter told the Commissioner about her experience when £100 belonging to her father went missing. When she tried to get the matter resolved she found that *"management keeps changing and Runwood aren't taking responsibility"* (for the missing money). She became so frustrated with Runwood that she reported her concerns to *"RQIA and Age Concern"*.
- A husband reported his wife's clothes going missing and her glasses *"were destroyed"*, while another son reported that his mother lost £100, a gold bracelet, clothing, her dentures and glasses. At that time the home did not keep an inventory of residents' belongings and items appeared to go missing on a daily basis.
- The son of one resident who was admitted in June 2014 reported that his father's watch went missing...*"it was never found or replaced...(I was) suspicious about where some of his designer clothes went...some of his trousers, track bottoms, socks and underwear... what he was given to wear were not his. It was as if all laundry was thrown in and re-allocated at random."*
- Another son reported that his mother's property went missing soon after her admission to Dunmurry Manor. *"Issues with laundry started within a couple of weeks, she was wearing other people's clothes and underwear, over £100 of items went missing though this has improved."*

- Senior Management within Runwood agreed that missing property and in particular laundry was a significant problem for the organisation. Runwood senior management stated, "*We have paid out vast amounts of money for alleged lost clothing.*"

The list of missing items reported to the Commissioner during interviews was extensive.

Findings of the investigation in relation to Care and Treatment

The following table is a summary of the investigation findings in relation to care and treatment of the older people residing in Dunmurry Manor:

	Theme 2: Care and Treatment (CT)
CT1	Poor and inadequate personal care, including inadequate individual assessments, poor quality of personal care and hygiene, care recorded as having been carried out when it had not and poor reported experience of residents by family.
CT2	Evidence of poor and inadequate care planning, including, incomplete resident care records, retrospective updating of care records, families not involved in care planning for their relatives, poor quality of information in care plan.
CT3	Inadequate assessment of anticipatory care needs including, inability of the home to deal with these needs and difficulties and issues experienced by residents reported by their families.
CT4	Evidence of poor and inadequate continence care, including poor quality of care, poor quality and non-availability of appropriate continence products and consistent issues reported by families of residents as well as former staff.
CT5	Poor and inappropriate skin and pressure area care including inadequate individual assessment, poor quality skin and wound care, non-availability / faulty pressure mattresses, poor reported experience of residents by family and inadequate training on wound and tissue viability.

	Theme 2: Care and Treatment (CT) (continued)
CT6	Poor nutrition including inadequate assessment, monitoring of food and fluid intake; lack of support for residents requiring assistance with feeding and issues surrounding availability and quality of food including special diets/pureed food; and concerns from families and workers about relatives'/ residents nutritional experience.
CT7	Inappropriate and unsafe moving and handling practices, including inadequate assessments and training; non- availability of necessary equipment or appliances and poor reported experience of residents by family.
CT8	Persistent falls management issues, including inadequate assessment and poor and incomplete reporting of incidents to families and relevant authorities; poor ongoing management of residents following a fall and inadequate evidence of reports of unwitnessed falls and injuries discovered later with no subsequent investigation.
CT9	Poor management of laundry and clothes and a disregard of personal preferences and personal possessions, including loss of money and jewellery.
CT10	Evidence that Dunmurry Manor was a home registered as a specialist dementia, previously "EMI"[17], care setting which was consistently unable to adequately manage the specific assessed dementia needs.

[17] Elderly Mentally Infirm, now dementia

Recommendations: Care and Treatment

R8: HSC Trust Directors of Nursing, as commissioners of care in the independent sector, should assure themselves that care being commissioned for their population is safe and effective and that there are systems to monitor this through the agreed contract between both parties.

R9: There should be meaningful family involvement in care and treatment plans and decision making at all key milestones. Electronic or written care plans should be available to families on request, including nutritional information.

R10: The Commissioner reiterates Recommendation 4 of the Inquiry into Hyponatraemia-related Deaths that, *"Trusts should ensure that all healthcare professionals understand what is required and expected of them in relation to reporting of Serious Adverse Incidents (SAIs)."*

R11: The Commissioner reiterates Recommendation 32 from the Inquiry into Hyponatraemia-related Deaths that Failure to report an SAI should be a disciplinary offence.

R12: Failure to have an initial six week care review meeting should trigger a report in line with SAI[18] procedures.

R13: The RQIA should pro-actively seek the involvement of relatives and family members as well as explore other routes to getting meaningful information, data and feedback on the lived experience in a care setting.

R14: The movement of residents by relatives to other homes should be viewed as a red flag and feedback should be obtained by the commissioning HSC Trust and the RQIA on the reasons for such moves.

R15: There should be adequate support and information provided to older people and their families when facing a decision to place a loved one in a care home. Each HSC Trust should allocate a senior health professional to oversee these placements and good practice. This would be greatly helped by the introduction of a Ratings System for care settings.

[18] A SAI – Serious Adverse Incident – further information available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/Guidance%20publication%20for%20reporting%20adverse%20incidents%20to%20NIAIC.pdf

4.3 Medicines Management

Conclusions: Medicines Management

The evidence gathered during the investigation supports the following conclusions in terms of the medicines management in Dunmurry Manor:

- The medicinal requirements of older people resident in Dunmurry Manor were frequently not met. There is evidence that some residents had prolonged periods where their medications were not administered due to omissions by staff
- Experiences of poor medicines management was a common theme of witness evidence
- Despite reporting of concerns by HSC Trust staff to Dunmurry Manor issues continued to arise
- Evidence that some residents displayed distressed and challenging behaviours during periods of medication mismanagement
- A resident was not given appropriate pain relief for a grade 4 pressure sore.
- Dunmurry Manor kept poor medicines records
- Relatives regularly had to travel to obtain prescriptions for their family member. This was frequently in the 'out of hours' period
- Families consistently felt excluded from decision making involving their loved ones

In recent years there has been a growing reliance on medication as the primary intervention for many illnesses. Older patients are more likely to be prescribed several different types and forms of medications due to their co-morbidities.

Medications are prescribed to benefit the patient. These benefits include the effective management of the illness or disease, slowed progression of the disease, and improved patient outcomes. However, patients receiving medication interventions are also exposed to potential harm. This can be the result of unintended consequences or side effects or medication errors, for example incorrect dosage being administered.

Nurses and social care staff are continually challenged to ensure that people receive the correct medication at the correct time due to excessive workloads, staffing inadequacies, fatigue, illegible provider handwriting, flawed dispensing systems, and problems with the labelling of drugs.

Legislation and Standards

The Nursing Homes Regulations (Northern Ireland) 2005: The registered person shall make suitable arrangements for the ordering, storage, stock control, recording, handling, safe keeping, safe administration and disposal of medicines, including that medicines must be stored in a secure place, (b) medicine which is prescribed as administered as prescribed to the patient for whom it is prescribed and (c) written record is kept of the administration of any medicine to a patient, apart from medicine that may be self-administered.

Standard 28: Medicines administered in strict accordance with the prescriber's instructions. There are suitable systems in place to manage drug alerts and safety warnings about medicines. There are robust incident reporting systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines. There are robust arrangements in place to audit all aspects of the management of medicines. Systems are in place to manage the ordering of prescribed medicines to ensure adequate supplies available and to prevent wastage. All medicines available for administration as prescribed. Medicines administered only to the resident for whom they are prescribed. Systems in place to prevent any over-ordering of medicines.

Standard 29: Medicines Records, be 'legible and accurately maintained as to ensure that there is a clear audit trail.'

Standard 32, Medicines are 'stored securely under conditions that conform to statutory and manufacturers' requirements.'

Standard 33: Medicines 'safely administered in accordance with the prescribing practitioner's instructions.'

An anonymised case study taken from witness evidence is outlined below:

Resident J

A Trust staff member stated that there had been several concerns raised about one resident. This Trust representative described Resident J (Res J) as 'over medicated' when they first met. This was raised as an issue and it was agreed that the Res J would be prescribed Risperidone rather than Diazepam. The Dunmurry Manor staff member informed Dunmurry Manor staff about this change in prescription. However, due to medication management errors Res J's Diazepam prescription was stopped with nothing to replace it, so Res J had 'nothing to settle [them].' As a result, Res J became very distressed and was described as 'climbing the walls.'

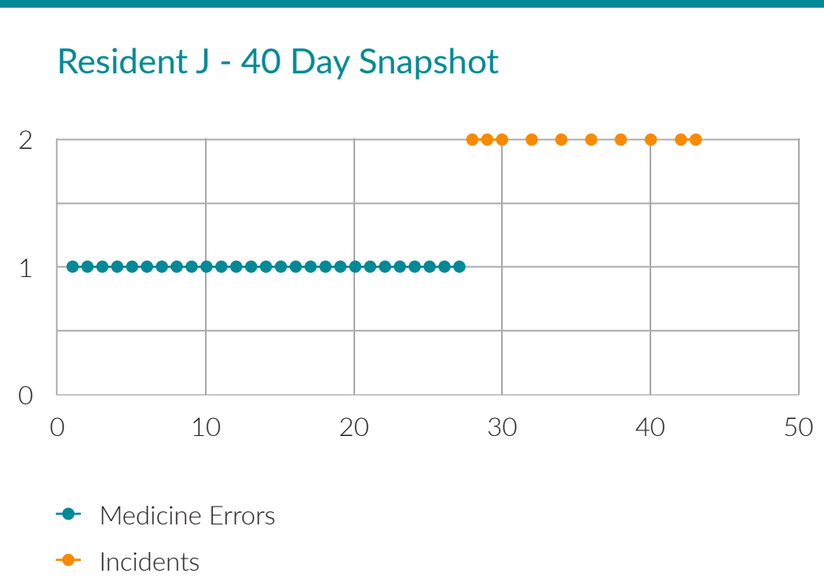
The HSC Trust staff member stated that Res J was displaying challenging behaviours and had numerous unwitnessed falls. At one stage ten unwitnessed falls were recorded in a three week period. Res J also entered a common room and displayed aggression. It was described that they 'hit all round' them. Res J was admitted to hospital following one such event. During the resident's time in hospital Res J became 'very well settled.' However, it became apparent that after a return to Dunmurry Manor Res J's new care plan was not being followed and within a week Res J was again displaying very distressed reactions and lashing out at other residents.

A 40 day "snapshot" of resident J's experience is summarised:

RESIDENT J – Medications Errors and Incidents

13.01.2016	Slapped other Resident
19.01.2016	Grabbed other Resident by the throat
18.02.2016	Hit member of staff with shoe
21.02.2016	Altercation with other Resident
29.04.2016	Pushed other Resident – altercation.
19.05.2016 – 14.06.16	Extra dose of Rispiridone which was not prescribed but added to the Kardex.
30.06.2016	Safeguarding Incident

3 Weeks previous to 30th June 2016, had "at least 10 unseen falls and aggressive behaviours" [according to Trust staff interview]



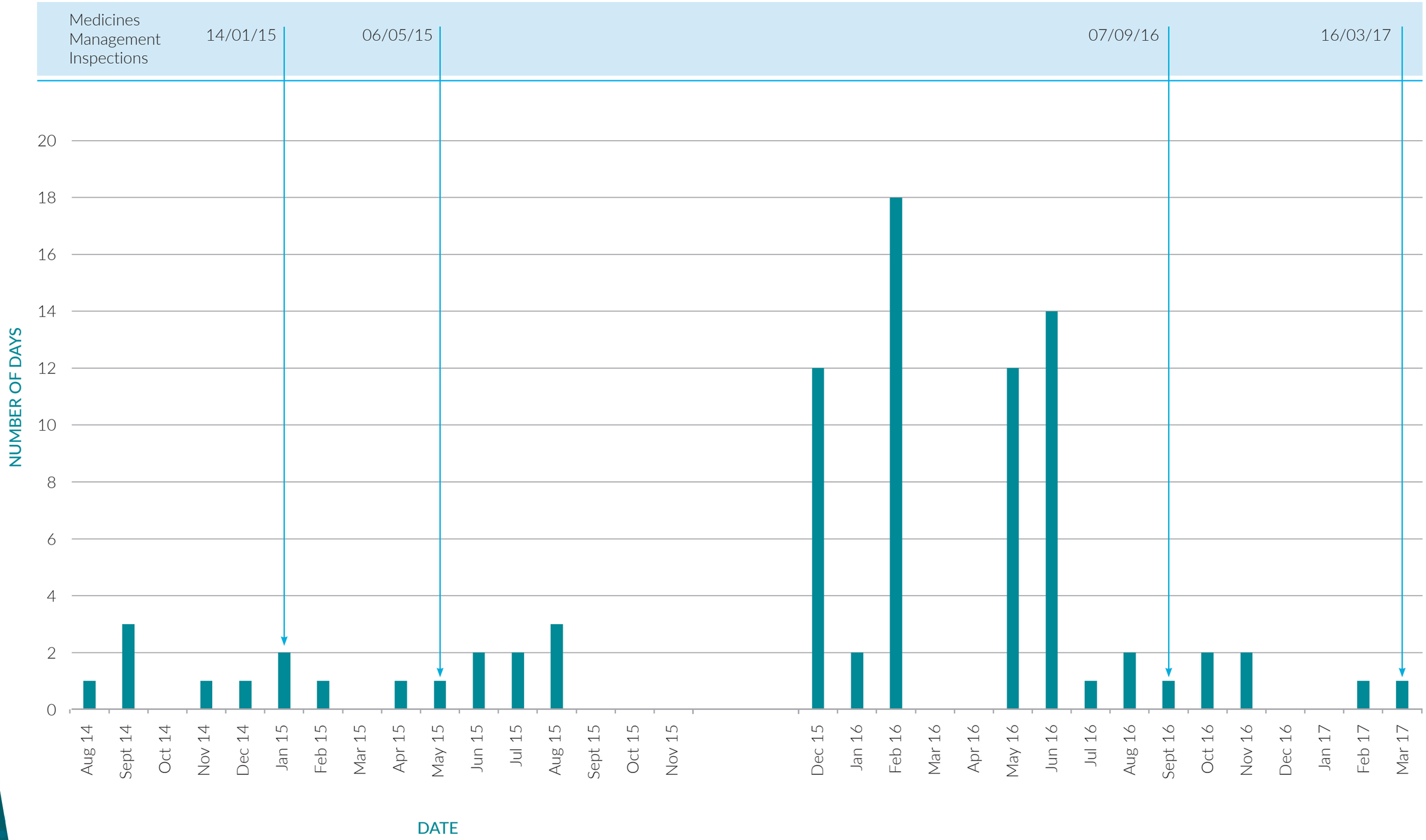
Medicines Management in Dunmurry Manor

Medicines management issues and concerns were often raised with the Commissioner in interviews with families and staff during the investigation.

Families highlighted that Dunmurry Manor often ran out of medicines and relatives had to take steps to resolve this problem themselves. Several relatives recounted attending the out-of-hours doctor to collect a prescription and then travelling to the pharmacy to pick it up before delivering the medication to the home. One relative, aged 88, was asked by the home to collect a prescription late in the evening from the pharmacy and then take it to Dunmurry Manor. Several residents' families also reported that prescribed medicines were at times just not administered, for days or even weeks. It is unclear how these serious omissions occurred but there was clear evidence that residents who failed to receive their medications had a deterioration in their behaviours with serious adverse consequences. Many of the improperly medicated residents consequently became physically abusive and even on occasion went missing from the home.

- One relative reported that in January 2016 medication was one week late, *"we were only told this because we specifically asked. Dunmurry Manor blamed [the pharmaceutical supplier] for this, we asked why could they not have bought it temporarily themselves."*
- The Commissioner was given evidence that several residents were not administered their prescribed medications for up to three weeks and staff failed to notice these omissions. Even when these residents' behaviours became challenging it appears that it took some time before staff became aware of any issues with medication. This caused significant distress for residents and their families and resulted in serious adverse incidents.
- Some of those interviewed wondered if residents were over medicated and this led to them having difficulty with activities of daily living. *"I asked to see the record of medication intake but was never shown it. I asked regularly. I thought they were hiding something. Once that allegation came out there was a clamming up. That sense of closed ranks here don't be saying too much. Dad slept loads in Dunmurry Manor 24/7. Just sleep, sleep, sleep. They weren't even worried about getting him out of bed. Now he's out of bed and in the chair. He is much more awake and alert in [another] Care Home. 100% better...up in the am and up all day. He had pressure sores on his bottom... doesn't have them now..."* [in the new nursing home].
- New employees reported that they had serious concerns regarding medicines management within Dunmurry Manor. One member of the Dunmurry Manor management team noted on starting employment in 2016 that the home *"frequently ran out of medications... medicines would go missing or have run out on a regular basis down to inconsistency in staff and medicines not being ordered on time...there were never enough staff to allow medicines to be given in a timely manner".*
- Another care team manager reported that *"medicines management was all over the place...but it has now improved...the problems were due to agency nurses."*
- One manager, who only remained in employment for a number of months in the home, found total mismanagement of medications on commencing in Dunmurry Manor. They stated, *"there was too much to be fixed by one person... I felt like I was drowning."* They had found medicines lying in cupboards which had not been destroyed after a resident had died or moved to another home. There was a lack of record keeping, over-stocking of some items and under-stocking in others. The lack of control and management of medicines concerned them greatly.
- Kitchen staff also observed poor practices. One witness stated, *"medications were left in containers in the resident's tables but no one stayed to check that they had been taken."* They also commented that this must also have happened at night, in the morning medications were often found on the floor. This staff member observed diabetic residents not being roused during the day to receive food and then they would suffer hypoglycaemic attacks. *"One diabetic resident who was put to bed in the afternoons. A few times they went into shock as they had not been wakened to be given a snack. They were supposed to have special medication- tablets but there were none so I had to run downstairs to the staff room to get a bottle of lucozade from the machine there...this happened regularly."*
- Another agency nurse reported seeing poor pain management. She noted that even when residents were prescribed analgesia, staff failed to meet the anticipatory care needs of a resident who had a grade 4 pressure sore and was evidently in pain.

Number of days when Medicine Errors/Issues occurred: July 2014 - March 2017



RQIA Medicines Management Inspections

The RQIA inspection reports for Dunmurry Manor are reviewed below (see Theme 5.) In that section a recommendation is made that the RQIA should introduce an integrated inspection model. At present (and during the period of this investigation) it currently carries out separate Medicines Management Inspections.

Since Dunmurry Manor opened in July 2014 five Medicines Management inspections have been carried out:

- 14th January 2015
- 6th May 2015
- 7th September 2015
- 16th March 2016
- 18th October 2017

The 14th January 2015 inspection report noted that the home was moving towards compliance with the minimum standards in respect of medicines management. Whilst no significant areas of concern were highlighted, the report stated six requirements and five recommendations relating to medicines management. The summary of the inspection report stated that the *"arrangements for medicines management are moving towards compliance with the minimum standards."* It further said that *"no significant areas of concern though some areas for improvement were noted"*.

Similarly, the inspection on the 6th May 2015 stated that there were no significant areas of concern and reported that the management of medicine was found to be safe, effective and compassionate. However, not all the requirements and recommendations from the first report had been met. These related to pain assessments being in place and the need to ensure that a care plan was in place which reflected the roles and responsibilities of care staff in the management of insulin dependent residents. In addition, the 6th May 2015 report noted the need for a recording system for medicines prescribed on a when-required basis for the management of distressed reactions.

A desktop review of the "Regulation 29 Reports" (Reg 29) for 2015 notes significant numbers of medications errors in the home across more than eight months. The April 2015 Reg 29 report specifically refers to *"concerns re medicines management"*, yet at the inspection on 6th May 2015 the management of medicine was found to be safe, effective and compassionate. The concerns raised one month before were not examined in the inspection reports.

The report from the 7th September 2016 RQIA inspection reported that some elements of the management of medicines promoted the delivery of safe care and positive outcomes for residents. There were however a further seven new requirements and six recommendations to ensure the management of medicines in the home supported the delivery of safe, effective and compassionate care. It was noted that *"the management of medicines supported the delivery of compassionate care"*. The report highlighted that there was limited evidence to indicate that the service was well led and it noted concerns regarding a deterioration in the service.

Although the Medicines Management inspection did not lead to enforcement action the subsequent Failure to Comply Notices (three) issued in October 2016 referred to failures to comply with the minimum standards relating to the assessment and management of pain. Reference was also made to the late provision of morning medication.

The next Medicines Management inspection was undertaken on the 16th March 2017. This was during the period of continuing non-compliance with the failure to comply notices imposed in October 2016. The inspection of the 16th March notes that areas for improvement regarding medicines management had been addressed in a largely satisfactory manner, except for cold storage and the safe disposal of medicines. Otherwise evidence observed during the inspection indicated that the management of medicines supported the delivery of safe, effective and compassionate care and that the service was well led. Improvements that had taken place were acknowledged and it was emphasised by the regulator that these improvements needed to be sustained. The 16th March 2017 inspection took place in the month following the highest recorded medicine incidents found by the investigation. This spike in medicine incidents was not reflected in the inspection report.

The most recent Medicines Management inspection at Dunmurry Manor was carried out on 18th October 2017 at which time a requirement relating to the cold storage of medicines was restated.

Findings of the investigation in relation to Medicines Management in Dunmurry Manor

The table below is a summary of the investigation findings in relation to medicines management for the older people residing in Dunmurry Manor:

	Theme 3: Medicines Management
MM 1	Medication errors / omissions leading to noticeable spikes in numbers of safeguarding incidents for residents (cross-reference with Theme 1).
MM2	Frequent examples of residents not getting medications on time, wrong medications or inappropriate dosages.
MM3	Ineffective process for the timely ordering and ongoing prescribing of drugs required by residents.
MM4	Inappropriate and unsafe drug storage, including drugs going missing.
MM5	Poor practices in management of drug dispensing and administration including relatives having to collect medications.
MM6	Poor record keeping in relation to medicines management.
MM7	Poor reported experience in relation to medicines management by residents' families.

Recommendations: Medicines Management

R16: Dunmurry Manor should consistently use a Monitored Dosage System for medicines administration which would prevent many of the errors identified in this investigation for the administration of regular medications.

R17: Care must be taken by staff to ensure any 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.

R18: Families of residents must have involvement in changes in medication prescribing. Explanation should be provided so that resident and family members understand the reasoning for any change.

R19: Staff should ensure it is clearly documented on each occasion why a resident might not be administered a medication.

R20: A medications audit must be carried out monthly or upon delivery of a bulk order of medication. This must be arranged with a pharmacist. To assist with more effective medicines management, providers of care homes should consider contracting with their community-based pharmacist (for a number of hours each week) to ensure that medicines management is safe and effective. The pharmacist could assist in staff training, identify where there are competency issues in the administration of medications and improve medicines governance within the home.

R21: The RQIA Pharmacist inspectors need to review all medication errors reported since the previous inspection and review the Regulation 29 reports in the home to ensure steps have been taken to improve practice.

4.4 The Environment And Environmental Cleanliness

Conclusions: Environment And Environmental Cleanliness

The evidence gathered during the investigation supports the following conclusions in relation to the environment and environmental cleanliness at Dunmurry Manor:

- Dunmurry Manor, a newly built home that was to serve as a specialist facility for residents with dementia, failed from an early stage to consistently provide the residents with a safe and clean environment.
- The Environmental cleanliness in Dunmurry Manor did not consistently reach the standards set out in the Nursing Home Standards. As recently as March 2017, Northern HSC Trust monitoring demonstrated unacceptably poor environmental cleanliness in residents' rooms.
- In some cases, the unacceptable lack of cleanliness represented a significant threat to the health and safety of residents. This includes concerns about residents' personal care and cleanliness, infectious disease outbreaks and the safety of residents if there had been a major fire on the premises.
- On the evidence provided by former workers and the RQIA reports there was an unacceptable lack of training on health and safety, fire safety and environmental issues.
- Whilst the physical building met the required standards for a residential and nursing home, the layout of Dunmurry Manor caused practical issues. The layout of corridors made it more difficult for members of staff to track residents' movements and location and the home was understaffed to provide the safe and compassionate care for the number of residents it had admitted.
- The security of Dunmurry Manor was not consistently maintained, with residents able to leave without staff becoming aware.
- There were many problems with the availability of equipment in Dunmurry Manor, limiting the ability to provide care and requiring, in some cases, residents having to share equipment or staff having to buy their own medical equipment.
- Despite environmental issues being frequently referred to in interviews and submitted evidence, there are very few references to these issues in RQIA inspection reports.

The environment older people live in is a key contributor to the quality of their care. Whether it be the design of a facility, the standards of cleanliness,

or the state of equipment. Flaws and failings in a home's environment have the potential to pose a serious risk to an older person's health, safety and enjoyment of their home.

Reflecting this, tools to assess the quality of life for those in care homes, such as the ASCOT model, list 'Accommodation, Cleanliness and Comfort' as one of their key domains of assessment. Even if a facility is cleaned to a very high standard, it is possible that the design of the home may make it an unsuitable place for some older people to live, especially those living with dementia. Each HSC Trust should consider the suitability of the home environment for their individual clients' needs. Those with dementia can particularly benefit from facilities with small scale living units, additional space for activities and good signage.[19]

Legislation and Standards

Standard 1 – 'Before Admission': *"Aids or specialist assessed equipment are in place before admission."*

The need for appropriate/sufficient aids or equipment is referenced in Standard 21 (health care, concerning those necessary for continence management), Standard 22 (falls prevention), Standard 23 (prevention of pressure damage), Standard 33 (resuscitation), Standard 43 (environment), Standard 39 concerning staff training and development, states that all staff required to use equipment and medical devices must have attended requisite training.

Standard 43 – Environment: 'The internal and external environment for the home is arranged so as to be suited to the needs of residents' – including:

- 'All furniture and furnishings in the home are suited to the needs of residents.'
- 'The environment is safe for residents with risks for falling and slipping minimised.'
- 'A noise management policy is in place…There is evidence that steps are taken within the home to minimise noise.'
- 'Bedrooms are personalised with the resident's possessions to suit their needs and preferences' – including name, photos, personal objects or memory boxes.
- 'Garden space is safe and secure and easy to find from inside the home.'

Standard 44 – Premises: 'The premises are safe, well maintained and remain suitable for their stated purpose'. The building must be 'kept clean and hygienic at all times in accordance with infection control best practice.'

'The procedures for maintaining the premises, grounds, engineering services and care equipment are in line with the relevant statutory requirements, approved codes of practice and the manufacturers' and installers' instructions.'

'The temperatures at all hot water outlets at wash hand basins, showers and baths accessible to residents are maintained in accordance with the safe hot water and surface temperature health Guidance Note.' – with the water temperature in areas used by residents being between 19-22°C.

[19] https://www.jrf.org.uk/report/designing-and-managing-care-homes-people-dementia

Standard 45 – Medical Devices and Equipment: 'Medical devices and equipment provided for residents' treatment and care are used safely.' This standard also requires:

- 'Staff have up to date knowledge and skills in using medical devices and equipment for the provision of treatment and care. There is a record of the training provided and competency demonstrated'.
- 'There are processes in place for the servicing, reporting of incidents, accidents and near misses. There is evidence of staff learning from such incidents.'

Standard 47 – Safe and Healthy Working Practices: 'The home is maintained in a safe manner':

- 'There are health and safety procedures which comply with legislation…and the maintenance of equipment'.

Standard 48 – Fire Safety, 'Precautions are in place that minimise the risk of fire and protect residents, staff and visitors in the event of fire.'

- 'All staff have training in the fire precautions to be taken or observed in the home, including the action to be taken in case of fire. The training is provided by a competent person at the start of employment and is repeated at least twice very year.'

The Nursing Homes Regulations (Northern Ireland) 2005, 27(4), (b) take adequate precautions against the risk of fire, including the provision of suitable fire equipment, (c) provide adequate means of escape.

Poor Practice

All those families interviewed by the Commissioner's office stated that they were initially very impressed with the environment and facilities on offer in Dunmurry Manor. Indeed, many families visited Dunmurry Manor prior to placing their elderly relative into the home and first impressions were extremely positive. The environmental cleanliness of the home appeared excellent and there appeared to be sufficient house-keeping staff to keep a high standard of cleanliness. Residents' rooms were spacious and comfortable as were the communal areas. Relatives appreciated that there was somewhere that they could go and have a cup of tea with their relative.

However, within a very short period after opening, in July 2014, families were starting to raise their concerns in relation to environmental cleanliness. The commissioning HSC Trusts were also noting their concerns and raised these with the relevant staff in Dunmurry Manor. There were some environmental issues in the early stages of the home opening, such as the supply of hot water and drains smelling and not always functioning properly. These were eventually rectified and the issues resolved.

Other environmental problems seemed more difficult to resolve and some interviewees gave the following information:

- A resident's sink remained broken for ten weeks. Resident E remained in the room but without use of his bathroom. A family member became so frustrated she offered to get a plumber to fix it herself.

- A staff member stated that the blood pressure monitor had been broken for so long that she bought her own. Batteries were missing from the blood pressure monitors and oxygen saturation monitors. Staff members were aware that there was a lack of continence pads available.

There were reports of problems with environmental cleanliness in Dunmurry Manor that appeared to be not just instances of poor practice, but a threat to the health and safety of residents. Those referred to in the submitted evidence by RAs included:

- Airflow mattresses being broken or disconnected from power
- Instances of EColi outbreaks in Dunmurry Manor – infecting residents with pressure sores
- Concerns about legionella checks
- Water pressure and temperature control

There were outbreaks of vomiting and diahorrea in Dunmurry Manor in April 2015, April 2016, norovirus in May 2016, from which the home was not clear of the causative factors for two weeks after the start of the outbreak and June 2016.

As recently as 10 March 2017 (a month after the Commissioner had commenced the investigation into Dunmurry Manor), a Northern HSC Trust report of a monitoring visit listed many instances of poor environmental cleanliness in resident rooms, including:

- Bed sheets not being clean
- Faeces on the floor
- Dirty rooms being signed as cleaned
- Urine stains on floors
- Dried blood and faeces on beds and chairs

The problems were not isolated – of the 60 rooms reviewed on that occasion, there was a cleanliness issue in 46 of them.

In contrast to RQIA inspection reports from this time, the inspection process did not have the same level of insight into this situation and did not reference inspecting individual resident's rooms. The 4th January and 27th January 2017 RQIA inspection reports did not reference inspection of residents' rooms. This divergence of observation is difficult to explain and in interview, RQIA officials were unable to provide an explanation.

The 16th March 2017 RQIA Medicines Management inspection referred to intelligence received about the cleanliness of Dunmurry Manor and that as part of the inspection cleanliness of some areas of Dunmurry Manor would be reviewed. The Inspectors found that *"following a tour of the home, review of patient bedrooms and bathrooms, it was evident that the home was well presented and clean. This was acknowledged with staff. No malodours were noted."* RQIA reports in 2016 reflect similar observations.

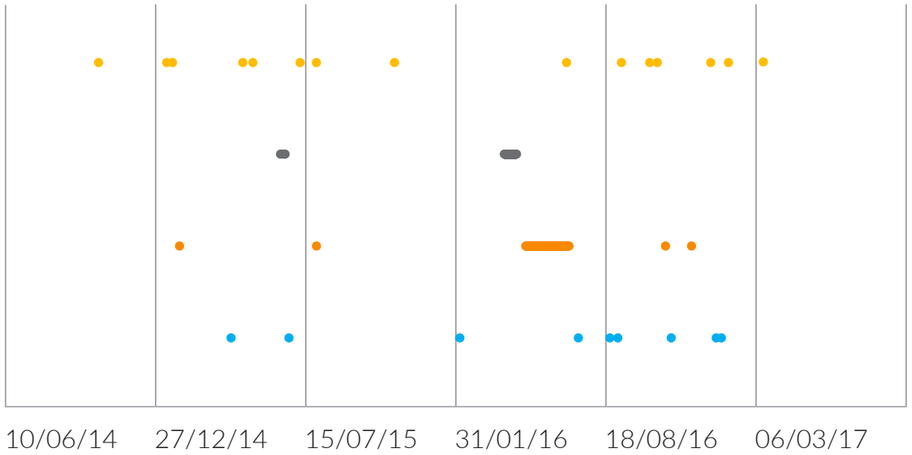
A care inspection report from the 17th October 2016 references that *"a review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, the dining room and storage areas. In general, the areas reviewed were found to be clean, reasonably tidy, well decorated and warm throughout. The majority of patients' bedrooms were personalised with photographs, pictures and personal items."*

The estates inspection report of the 24th October 2016 examined issues around water temperature, fire alarms, lifts and other equipment and does not mention cleanliness in rooms or in shared areas of Dunmurry Manor. Additionally, a 24th June 2016 care inspection report states that *"the home was evidenced to be fresh-smelling, clean and appropriately heated."* Other inspection reports in 2016 do not discuss cleanliness and hygiene within Dunmurry Manor.

The findings of the monitoring visit by Northern HSC Trust officials in March 2017 combined with reports from interviewees of other issues and incidents that happened in Dunmurry Manor, indicate clear breaches of Standard 44, including the requirement for the building to be *"kept clean and hygienic at all times."*

Evidence submitted in investigation interviews included references to residents' continence products not being changed and residents' being found soaked with urine, or bags of used continence pads being left on the floor / in the residents' rooms. One family member recounted coming in one day to a *"horrific"* smell, another reported examples of *"faeces on the curtains and night clothes"*. A further witness advised the Commissioner that not all the kitchen assistants had achieved basic food hygiene certificates and that Runwood Head Office would not support them obtaining them even when it had been agreed within Dunmurry Manor management that this basic training should be done. No evidence to counter this was ever provided by Runwood.

Hygiene and Equipment Issues (and corresponding sickness outbreaks) June 2014 - March 2017



Hygiene and Equipment issues in this graph include Sickness Episodes (an episode of sickness affecting a number of residents in the home that lasts for a prolonged period), Equipment (the equipment intended to assist the care of residents being unavailable, damaged or unable to be operated), and Cleanliness (areas of the Home not being cleaned, furniture/objects in the Home not being cleaned, waste products not being disposed of/binned correctly).

Design of the Home

Whilst families were initially impressed with the environment of Dunmurry Manor, a number of staff told the Commissioner that they had concerns regarding the design and layout of the home. They expressed concerns about the length of the corridors and dead ends where residents could congregate and not be visible to staff who were responsible for monitoring residents. The nurse and care staff station was located in the centre of the building rather than one at each dead end of the corridor.

A care setting may be able to be "signed off" by the RQIA as ready to receive residents but that does not mean that the design or layout of the home meets dementia-friendly design standards. Regrettably design and layout are not a requirement for a home which specialises in dementia care.

One HSC Trust member of staff identified a problem with the 'U shape' of the home, because residents clustered in corridors and this could create opportunities for falls and resident on resident assaults or altercations. Another HSC Trust employee thought Dunmurry Manor was laid out poorly and should have the dementia unit downstairs and the residential unit upstairs (as the residents in the residential unit were generally more mobile and able to use stairs and lifts). One former member of staff at Dunmurry Manor expressed concerns that the unit was simply too big for the limited number of staff employed and on duty.

"The rooms can be beautiful but it is basically a gilded cage" was how one former staff member described Dunmurry Manor environment.

Equipment

Members of staff from Dunmurry Manor recounted examples of delays in ordering essential equipment and supplies and of restrictions placed on ordering by shared budgets with other departments. One former member of staff recalled having to *"buy stuff out of my own pocket; you would give them your receipt but you would never see the money again."* Others recounted that orders would not appear or head office would decline them – one order for hats and tea towels had not appeared six months after ordering with no explanation of why.

Security

Given the resident profile in Dunmurry Manor, with most residents living with dementia, it was important that security of the environment was of the highest standard. Residents were required to be kept safe and secure within the home and steps taken to safeguard them from any environmental risks. However, there were incidents which occurred when residents were unaccounted for and were not found by staff from Dunmurry Manor. These were occurring relatively soon after Dunmurry Manor opened. Two residents managed to climb over a wall in August 2014 and January 2015 and were escorted back to the home by staff and one resident by the PSNI.

Another resident was found three streets away in the snow on two occasions in January and March 2015. In 2016, there was an incident where two residents left the home, and approximately three hours later one resident was taken back to Dunmurry Manor by a neighbour and one by the PSNI. There were also some incidents where residents were still in Dunmurry Manor but were not accounted for when initial searches took place. In at least one case the resident's family was contacted and put through the distress of being told they were missing before the resident was found. Conversely, families and the HSC Trust on occasions were not made aware when residents had managed to leave the home unaccompanied and unobserved.

Fire Safety

The lack of evidence of fire safety expertise in Dunmurry Manor was another area of concern in both documentation and witness evidence. There were various problems with the fire doors resetting. Before the Dunmurry Manor building was registered as a nursing home with the RQIA, a *'dead end condition'* was identified in the home, where if a fire had broken out only one escape route would be available. This affected three residents' rooms who would need to be prioritised and assisted by staff in the event of an evacuation. This was accepted as a plan to manage this part of Dunmurry Manor but was not supported by witness evidence from former staff.

However, in 2015 a representative of the RQIA voiced their concerns regarding the level of fire safety training undertaken, with an example cited of staff not recognising when a patient was setting off the fire alarm. Staff were on record as saying their training was poor and they were not told how to respond to the fire alarm. Other staff reported not being told where the fire doors were, while one former member of staff said the fire drills were *"hopeless."* It is difficult to be assured that staff were sufficiently trained and aware of fire protocols to safely evacuate residents from areas like the 'dead end' corridor in the event of a major fire. The provisions in the 2005 nursing home regulations and Standard 48 of the nursing home standards about safe escape from fire and all staff having training and knowledge of what to do in the event of a fire were not met. This is evidenced by testimony of former staff to the Commissioner and instances of unsatisfactory responses to fire alarms quoted in inspection reports (15/10/2014, 21/01/2015).

These five different areas, which contributed towards problems with the environment in Dunmurry Manor all appear to contradict aspects of the RQIA's 'Key Indicators for Inspectors' - especially in assessing 'Is Care Safe?' These include the following:

- Equipment and medical devices are available, well maintained and regularly serviced
- Adequate precautions are in place against the risk of fire
- Arrangements are in place to maintain the environment e.g. Servicing of lifts, boilers, electrical equipment, legionella risk assessment
- There are no malodours noted within the home.[20]

The evidence given to the investigation is that there were consistent examples of Dunmurry Manor falling short of these indicators and is a further signal that Dunmurry Manor was not providing safe and effective care.

[20] https://www.rqia.org.uk/RQIA/files/9e/9e59168c-003e-461d-9f1d-a32fa400dd5e.pdf

Findings of the investigation in relation to Environment and Environmental Cleanliness

Cleanliness, the layout of Dunmurry Manor and equipment issues and concerns were consistently raised with the Commissioner in interviews with families and staff during the investigation.

The table below is a summary of the investigation findings in relation to the environment and environmental cleanliness for residents of Dunmurry Manor:

	Theme 4: Environment and Environmental Cleanliness (EC)
EC1	Reported poor environmental cleanliness, health and safety.
EC2	Concerns raised that the physical environment is not conducive to the management and safety of residents with complex needs.
EC3	Non-availability of medical equipment and machinery which was properly functioning (as well as fixtures and fittings).
EC4	Lack of evidence of fire safety expertise, training and fire drills.

Recommendations: Environment and Environmental Cleanliness

R22: It must be a pre-registration requirement for RQIA and a pre-contract requirement for HSC Trusts that all new care homes specialising in dementia care comply with dementia friendly building standards (and that buildings already in place are subject to retrospective "reasonable adjustment" standards).[22] This must form part of periodic inspections to ensure suitability is maintained.

R23: Premises must be one of the areas that RQIA inspectors routinely inspect as an integral part of an integrated inspection with a focus on the condition of residents' rooms.

R24: Runwood must devolve goods and services budgets to a local level for staff to manage.

R25: The RQIA must review how effective inspections are for periodically covering all of the regional healthcare hygiene and cleanliness standards and exposing gaps that a home may have in relation to these.

R26: Consideration should also be given to expanding these Standards in line with the NHS 'National Specifications for Cleanliness', which emphasise additional issues like the cleaning plan of the home and a specified standard of cleanliness for different parts of the home/different types of equipment.

R27: The programme of unannounced 'dignity and respect spot checks' should also include assessment of the suitability and state of the environment. In Dunmurry Manor the breaches of key environmental indicators raise the question of whether residents were being treated with appropriate dignity and respect and whether this should have triggered warning signs about Dunmurry Manor at an earlier stage.

[22] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75240

4.5 Regulation And Inspection

Conclusions: Regulation And Inspection

The evidence gathered during the investigation supports the following conclusions:

- A very significant finding from this investigation has been the apparent disparity between the evidence gathered by the Commissioner which overwhelmingly demonstrates failures in care at Dunmurry Manor which are not in accordance with the findings of inspection reports.
- 23 inspections were completed over a period of 39 months. This seems a high number (given the recent proposal by the Department to move from a minimum of two to one inspection per annum). However, the targeting of inspections at poorer performing homes should be the priority for the RQIA. Such an approach would only work well as part of a sustained programme of improvement work carried out in partnership with the provider of the care home, the relevant HSC Trusts and the RQIA.
- In the case of Dunmurry Manor the Commissioner is of the opinion that there is limited evidence of such a coordinated and sustained approach having been taken particularly when the evidence led to three Failure to Comply Notices being served on Runwood.
- At the point of issuing the FTCs a clear improvement plan should have been the priority of the RAs to ensure that the residents in Dunmurry Manor were receiving safe, effective and compassionate care.
- It is clear from the inspection reports that only a very small number of relatives, visitors or representatives were spoken to during inspections. There is little evidence of a thorough approach to obtaining the views of relatives being taken by the RQIA. From review of the inspection reports it would seem that the views of only 14 relatives, visitors or representatives were obtained in the first year of the home operating. Since that time there have generally been very low numbers of relatives contributing their views on the care delivered at Dunmurry Manor as evidenced in the inspection reports.
- Staff were reluctant to be seen talking or communicating with RQIA inspectors during inspections due to a fear of reprisal from management.
- There is little value in undertaking separate inspections for Care, Medicines Management, Premises and Finance. The Commissioner would like to see integrated inspections introduced as soon as possible. Although the investigation team has been told about consideration of this approach, it appears that this has not yet progressed to implementation.
- At the point at which the failure to comply notices were issued the evidence available to the Commissioner would lead to the view that more decisive action should have been taken to protect the wellbeing of the residents at Dunmurry Manor.
- The length of time given to make improvements to the care being delivered at Dunmurry Manor must be emphasised. The failure to comply notices were issued on the 25th October 2016 however at the 4th January 2017 inspection there was no evidence of full compliance and a decision made on the 5th January 2017 to extend the compliance date to the maximum legislative timeframe of 90 days i.e. the 27th January 2017. Compliance was not achieved by that date and thereafter a notice of proposal to issue conditions on the registration of the home was served on the 6th February 2017. Despite further inspections it was not until the inspection of the 28th July 2017 that the registration conditions were removed. This was nine months after the serious concerns highlighted in the late October 2016 inspections.
- This raises a fundamental question over the time which should be allowed for improvements to be made that will give assurance that these will be sustained over time. During this timeframe there remained serious concerns regarding the welfare of the residents in Dunmurry Manor. How long is long enough to work in a collaborative way to ensure that older people are protected and well cared for in a care home? In this instance it is the view of the Commissioner that there was an inadequate response to the contravention of regulations.
- There is often no apparent clarity in the way inspection reports are written which would give a quick and clear picture of the assessment which the RQIA has given of the quality of the services being delivered by care homes. Whilst the Commissioner's team has been advised about *"work ongoing"* to consider the introduction of a performance rating system for care homes, to date this has not been implemented.
- There is no evidence of lay assessors/ inspectors being used in any of the inspections at Dunmurry Manor and the Commissioner would ask the RQIA to review its approach to the use of lay assessors/ inspectors.
- None of the inspections were carried out during the night or at weekends. Given the substantial number of incidents reported to the RQIA, inspections should have been carried out at the weekend or during the evenings to capture the full picture of Dunmurry Manor. A number of the incidents reported occurred at night or at the weekend.
- In 2014 an independent consultancy report recommended that the RQIA discuss with the (then) DHSSPS the opportunity to change the fees and frequency regulation and move to a *"risk-based approach to inspection"*.
- Whilst the Commissioner would not disagree with this recommendation and has noted in this report that inspections should indeed be targeted at poorer performing care homes within the

approach of an integrated inspection model, Dunmurry Manor was inspected 23 times in 3.5 years.

- The same consultancy report also recommended in 2014 that the RQIA moves to a single inspection model of inspection that covers areas critical to patient safety. Review of the board minutes of the RQIA demonstrate that work has begun on some of the changes recommended since 2014, however the pace and scope of the changes in that time is inadequate and a number of key changes and improvements have not yet reached implementation.

The RQIA registers and inspects a wide range of health and social care services. These inspections are based on care standards which are set to ensure that both the public and service providers know what quality of services can be expected.

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"*. This legislation does not however prescribe how this role should be carried out. It is the responsibility of the RQIA Board and Executive team to determine the best approach to carry out its functions.

In Northern Ireland inspections by the RQIA take place on an unannounced basis (since 2015). The current inspection process has seen a degree of change since the previous Commissioner reported in 2014 in the *"Changing the Culture of Care in Northern Ireland"*. At that time the inaugural Commissioner recommended that:

- 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.
- 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.
- 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.

Since 2014, the Commissioner's office has continued to be involved in legal advocacy and casework concerning the experiences of older people in care settings across Northern Ireland. The Commissioner retains an active interest in inspection processes and considering whether these processes accurately examine key signs which relate to the *'quality'* of the individual's experience within the care setting.

Legislation and Standards

The following Standards apply;

Regulation 34 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Each Board and Trust shall put in place arrangements for monitoring and improving the quality of the health and personal social services which it provides to individuals and the environment in which it provides them.

Regulation 35(4) - if the RQIA is of the view that the body or service provider being investigated, the health or personal social services are of 'unacceptably poor quality' (a) or (b) there are 'significant failings in the way the service is being run, then (5) the RQIA may recommend that the Department take special measures in relation to the service provider.

Regulation 39 can issue an improvement notice on an agency if they believe they are failing to comply with any statement of minimum standards, which will specify in what respect there is a failure to comply, and what improvements are considered necessary.

Regulations 12-27 deal with the registration of managers, registered persons and of the home. 12(1) says that 'any person who carries on or manages an establishment or agency of any description' without being registered shall be guilty of an offence. Regulation 15 (1) (c) provides for the cancellation of registration of a person 'on the ground that the establishment or agency is being, or has at any time been, carried on otherwise than in accordance with the relevant requirements.'

Regulation 38 states that the Department will publish and amend minimum standards and these should be taken into account by the RQIA around decisions to cancel registrations.

Regulation 39 gives the RQIA the power to serve an improvement notice on a registered person if they believe they are failing to comply with the minimum standards.

Regulation 40 gives the RQIA power to 'at any time enter and inspect premises' and require the Manager to provide them with relevant information.

Regulation 41 gives the RQIA powers to request relevant information from a HSC Trust or service provider to provide it with relevant information.

RQIA Enforcement Policy (April 2017) states that enforcement action will be 'proportionate and related to the level of risk to service users and the severity of the breach of regulation'. RQIA will follow up enforcement action to ensure that quality improvements are achieved

Dunmurry Manor was registered by the RQIA on the 16th July 2014 as a residential and nursing home with a ground floor accommodating 36 residents with dementia and on the first floor 40 patients with dementia requiring nursing care.

Set out overleaf are two examples of anonymised testimonies from witnesses interviewed as part of the investigation which are relevant to this particular theme:

Re: RES K

A relative of Resident K told the investigation team:

"On two occasions the RQIA were inspecting whilst I was there. On the first I approached the inspector and asked them to attend at a care meeting about my relative which was due to take place that day. The inspector agreed to do so. The inspector attended however left after ten minutes and there was no further contact or follow up from them afterwards.

On another occasion, I asked a different inspector who was downstairs to please come and meet with residents and their families upstairs. The inspector did not do so.

I felt that concerns by Trusts or the RQIA should have been brought to the attention of relatives at the outset. I was also not made aware that inspection reports were available to the public."

Re: RES D

Resident D's relative told the investigation:

"I was not aware of any concerns having been raised by Trusts or the RQIA before placing my relative. These should have been brought to our attention at the outset. Our family was not made aware that inspection reports were available prior to placing our loved one in Dunmurry Manor.

When I contacted the RQIA after my relative's accident, I was told that I should go to the Trust with my concerns, that the RQIA was there to "regulate only" – I found this strange. With hindsight, our family did not know the role of the RQIA – I am still confused as to their role. I think that the RQIA is useless and not fit for purpose. There needs to be a change in legislation in how care homes are run."

Observations From Evidence

Some experiences of residents, especially in respect of unexplained severe weight loss and grade 4 pressure sores raise concerns of neglect. Interviews with relatives, former staff and some HSC Trust staff revealed numerous serious incidents and red flags in relation to care. This is in stark contrast to what RQIA inspectors gleaned from relatives in their discussions and questionnaires.

A number of former Dunmurry Manor staff told the Commissioner that they were instructed not to speak to RQIA inspectors. They reported that if any of them were seen speaking to inspectors they were immediately interrogated by senior staff as to what they had said. RQIA therefore did not hear these messages of concern and it appears that few issues of complaint were raised with them during inspections.

While the South Eastern HSC Trust had concerns from an early stage regarding the fundamentals of care in Dunmurry Manor. Some HSC Trust managers found it difficult to escalate these concerns within their organisation. Others frequently rang the inspectors in RQIA to raise their concerns. The monitoring visit by a member of staff of the Northern HSC Trust on 10 March 2017, of every resident and their rooms, was so concerning that urgent meetings were immediately held with the other HSC Trusts. RQIA was forwarded a copy of the schedule of findings. These were consistent with those identified in this investigation and included: a lack of person centred care, poor staffing levels, lack of record keeping, issues with administration of medications and significant environmental cleanliness issues, especially foul smelling bathrooms and bedroom carpets.

RQIA then carried out an unannounced Medicines Management Inspection six days later on the 16 March 2017. The catalogue of failings identified by the HSC Trust officials the previous week were not found or reflected by the RQIA inspector. The Commissioner and indeed commissioning HSC Trusts were surprised at this outcome, especially as many of the failings would have taken some time to rectify appropriately. A further HSC Trust monitoring visit on the 27 March 2017 showed some improvements but there were still issues regarding the quality of care.

A HSC Trust official voiced their concerns stating: *"The 10 and, 27 March 2017 reports were copied to RQIA. As a matter of course, we pass to RQIA directly to be kept in touch with what is going on, they do not always come back to you. Often have to chase them. I would have worries about what they do with this information."*

It is difficult to understand why there would be such a difference of opinion between the HSC Trusts and the RQIA in assessing the quality of care and the level of service being delivered in Dunmurry Manor.

It is clear that the RQIA had Dunmurry Manor "on their radar", which is evidenced by the number of inspections carried out. For the purposes of outlining the differences between the inspection reports published on Dunmurry Manor and the investigation findings, a chronology and summary of the inspections is outlined on the pages which follow, alongside a list of some of the incidents which were raised with the Commissioner's office and which were received as part of the disclosure of documentation relevant to the investigation.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings And COPNI Investigation Findings

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
1. July 2014 Pre-Registration Inspection (only RQIA inspections are numbered in this column)	Home opens; 1st home manager appointed	Dunmurry Manor was registered by the RQIA on the 16.07.14 as a residential and nursing home with a ground floor accommodating 36 residents with dementia and on the first floor 40 patients with dementia requiring nursing care	• Concerns about one corridor in event of fire before Dunmurry Manor opened – requirement for fire training and inductions which were not given to all staff. • This became a subsequent concern from RA's in terms of how staff would deal with outbreak of major fire in Dunmurry Manor. • Concerns were subsequently raised about the design of the building, its size in relation to staff and 'U shape' design, led residents to wander and cluster in corridors.
End August 2014	1st Manager resigns		Manager 1 in post for 7 weeks
2. Oct 2014 Unannounced Secondary Care Inspection - 5 Requirements and 7 Recommendations.		RQIA had received concerns from the SE HSC Trust regarding practice at Dunmurry Manor. Only 1 visiting relative was spoken to during the inspection. The inspection found: • insufficient numbers of staff • issues with the quality of nursing provision, record keeping, staffing levels, the quality of staffing, food and fluid provision.	• Incidents 07/14 – 01/10/14: Medicines 4, Pressures Sores 1, Staff Issues 1, Falls 4, Altercations 2. • Serious issues included staff verbally abusing residents, missed medicines, poor pressure care, severe weight loss and unauthorised entry to resident rooms. • Residents were admitted with no pain assessments, no weight or MUST documentation and no body maps. • All of these issues would feature again at points in the next 3 years, with many still happening in 2017.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
Mid Oct 2014	Runwood voluntarily close to new admissions	As a result of the inspection (above) the management of the home voluntarily cease new admissions.	Prior to the next inspection, there were incidences of residents being unaccounted for at night, a resident attempting to exit Dunmurry Manor premises after not being administered correct meds, and residents neglected.
3. Mid-January 2015 Medicines Management Post Registration Inspection: 6 Requirements and 5 Recommendations.	3rd Manager - Runwood a "regional" employee in Dunmurry Manor as "Acting" manager	The report noted that there were no significant areas of concern though some areas for improvement were reported particularly relating to record keeping. This report did not follow up on the requirements and recommendations highlighted in the first Care report. This is the practice of the RQIA and a consequence of operating a system of separate Care, Medicines Management, Premises, and Finance Inspections.	• Incidents from 02/10/14 – 14/01/15: Medicines 3, Pressure Sores 4, Staff Issues 3, Neglect 2, Falls 9, Significant Weight Loss 1, Altercations 11, Residents Unaccounted for 6, Violation of Room 3, Unexplained Injuries 3. • There had been 7 medicines incidents since Dunmurry Manor opening, and a Medicines Audit in November had found Medicines missing. The January 2015 Inspection Report, while noting discrepancies, does not fully reflect these issues. • There were serious incidents during this time - resident fights, residents found in other residents' rooms and outside the premises. Instances of neglect with UTI's and dehydration - one resident passing away and another suffering from significant weight loss. In one case inadequate records hampered an investigation.

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
4. End January 2015 Unannounced Care Inspection - 17 Requirements and 9 Recommendations. 3 requirements were stated for the second time.	2nd Manager resigns - Manager in a "regional role" – assumes "Acting Manager" position (3rd Manager)	There was one notification regarding a safeguarding matter. This Care inspection took place only a week after The Pharmacy Inspection and three months after the first Care Inspection. Once again only one relative was spoken to and no questionnaires seeking the views of relatives were sent out. Questionnaires were however issued to staff. The RQIA had concerns that quality of care and service fell below the minimum standards expected: nursing care specifically in relation to dementia practice, the use of restrictive practice for patients, continence management, staffing arrangements, staff training and the fitness of the premises regarding cleanliness.	• Incidents 15/01/15 - 21/01/15: Altercations 1. • Manager 2 in post for 5 months. • RQIA aware a third of staff had not completed mandatory training, significant areas need deep clean, malodors in bedrooms, infection control guidelines not adhered to. • Complaint to RQIA by former staff (February 2015) references bad practices - hygiene, food, mobilising, activities, communication, lack of training and staff. • Trust officials were expressing concern about how many times Dunmurry Manor were stating things would improve, but not being able to deliver the improvements. • A complaint by a family reflected that their relative had not been washed or changed for seven days. • The first report of no hot water throughout the building occurred during this time.
Mid (11th) February 2015		Serious concerns meeting with RQIA. The issues above were reported to the senior management at the RQIA and as a result a serious concerns meeting was held on the 11th February 2015.	Incidents 22/01/15 – 11/02/15: Medicines 1, Falls 4, Environment/ Equipment 2, Unexplained Injuries 1.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
5. April 2015 Unannounced Care Inspection – 1 Requirement and 2 Recommendations.		The reporting format had changed with a focus on reporting in relation to whether the care was safe, effective and compassionate. Two relatives were spoken to during the inspection. A requirement was made in relation to continence assessment and care planning and two recommendations regarding the auditing of care records.	Incidents 12/02/15 – 05/04/15: Medicines 1, Pressure Sores 1, Falls 3, Altercation 3, Residents Unaccounted for 1, Unexplained Injuries 1.
6. May 2015 Unannounced Medicines Management Inspection - 0 Requirements and 4 Recommendations - Of the six requirements made at the previous pharmacy inspection on the 14th January 2015, 3 had been met		No significant areas of concern however some areas for improvement were identified. These related to there being no care plan for the management of an insulin dependent patient, no pain assessments in place for 3 of 5 randomly selected patients, the need for a recording system for medicines prescribed on a when required basis for the management of distressed reactions and the need to ensure that care plans were maintained for each patient who is prescribed medicine for the management of pain.	• Incidents 06/04/15 - 06/05/15: Medicines 1, Neglect 1, Environment/ Equipment 1, Altercation 1. • There was another outbreak of Vomiting and Diarrhea in Dunmurry Manor during this time. • One resident was given none of their course of antibiotics for 10 days during this time. • An April 2015 Reg 29 Report identified areas of poor practice in the medications management systems. • A resident was pushed to the floor by another resident who had not been given their medications that week. They suffered a fracture in the fall. • One resident (who also went 5 days without continence pads being changed) exited Dunmurry Manor twice within a week.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
7. July 2015 Unannounced Care Inspection - 4 Requirements and 2 Recommendations.		The next Care inspection was carried out on the 9th July 2015 once again a period of nearly three months from the previous Care inspection - concern and areas of improvement were to ensure that care in the home is safe, effective and compassionate. No relatives were spoken to during the inspection.	Incidents 04/05/15 – 09/07/15: Medicines 3, Environment/Equipment 2, Altercations 6.
8. July 2015 Unannounced Finance Inspection: 5 Requirements and 1 Recommendation		A Finance inspection was carried out on 30th July 2015. The inspection found care to be compassionate, safe and effective. Regarding the management of finances there were some areas for improvement.	• Incidents 10/07/15 – 30/07/15: Medicines 1, Environment/ Equipment 1, Altercation 2, Residents Unaccounted for 1 • South Eastern HSC Trust note increase in Safeguarding referrals.
End August 2015	Manager 4 appointed "Acting Manager"		• Manager 3 resigns after being in post for 6 months • Manager 4 in post for 10 weeks

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
9. November 2015: Unannounced Care Inspection (11 Nov) . This was the 7th RQIA inspection in 2015. 3 requirements and 8 recommendations. 2 recommendations were reported for the second time.	Manager 5 appointed	This Care inspection was "themed" - underpinned by Standard 19, Communicating Effectively, Standard 20, Death and Dying, and Standard 32 Palliative and End of Life Care. On the day of the inspection care was found to be safe, effective and compassionate. No significant areas of concern were reported however there were some areas for improvement. At this inspection 5 patient representatives were spoken to.	• Incidents 31/07/15 – 11/11/15: Meds. 4, Staff Issues 4, Neglect 4, Falls 1, Altercations 4, Sexual Incidents 1. • HSC Trust officials questioning designation as EMI - not accepting residents who previously displayed challenging behaviours. • The second half of 2015 saw an upsurge in incidents and poor practice - with residents receiving the wrong medication, being involved in assaults or exiting the premises. One resident was receiving a double dose of their medicines for 27 consecutive days. • Testimony given to the Commissioner from an agency nurse reflects a practice of managers telling nurses and care assistants to get residents up early because of backlog of tasks had started.
February 2016	Manager 5 resigns Manager 6 appointed		Manager 5 in post 3 months

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
10. June 2016 Unannounced Care Inspection – 2 Requirements and 5 Recommendations.		There were weaknesses in the delivery of safe care in relation to staffing arrangements and the deployment of staff, the lack of a robust system to monitor the registration of care assistants, the validation of the staff induction training programme, and arrangements for locking doors in the home and the garden area at the back of the home. Two requirements, dependency levels must be kept under review to ensure that the numbers and skill mix of staff is appropriate and a robust system for monitoring the registration of staff must be in place.	• Incidents 12/11/15 – 24/06/16: Medicines, 4 separate incidents (31 cumulative days), Pressure Sores 3, Staff Issues 3, Neglect 7, Falls 1, Environment/Equipment 3 separate incidents (72 cumulative days), Significant Weight Loss 1, Altercations 23, Residents unaccounted for 2, Unexplained injuries 1, Sexual Incident 2. • Resident A taken to hospital following serious fall. Family met with Manager and South Eastern HSC Trust Manager contacted Dunmurry Manor re the incident. • End June – South Eastern HSC Trust commence Safeguarding investigation regarding Resident A. • July - Runwood state they are investigating resident's case. • End of July - South Eastern HSC Trust investigation into Resident A case concludes. Family lodge formal complaint following week. • The inspection criticised Dunmurry Manor for non-implementation of HSC Trust professionals' recommendations including close obs. records being completed largely in retrospect, incomplete and falsified records, poor communication, lack of staff.
August 2016	Manager 6 resigns; Deputy Manager – "Acting up", Manager 7		Manager 6 was in post for 5 months

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
11. September 2016 Unannounced Medicines Management Inspection - 7 Requirements and 6 Recommendations		This pharmacy inspection was 16 months after the last Pharmacy inspection. It was reported that some elements of the management of medicines promoted the delivery of safe and positive outcomes for patients. However, the report highlighted that there was limited evidence to indicate that the service was well led. The report noted concerns regarding a deterioration in the service. One relative was spoken to.	• Incidents 25/06/16 – 07/09/16: Medicines 1, Pressure Sores 2, Staff Issues 1, Neglect 4, Falls 3, Environment/Equipment 4 separate incidents (9 Days), Altercation 3, Violation of Room 1, Unexplained Injuries 1, Sexual Incident 4. • During this time a resident who had been involved in earlier sexual incidents in Dunmurry Manor was reported as seen leaving bathrooms with another resident appearing dishevelled. Some of these incidents were not reported to the relevant HSC Trust.
October 2016	Manager 7 resigns		Manager 7 was in post for 2 months.
12. 17-18 October 2016 Unannounced Care Inspection – 12 Requirements and 6 Recommendations.	Manager 8 appointed (on day 3 of inspection)	Weaknesses were identified in the delivery of safe care and effective care. Regarding compassionate care a recommendation was made that the negative comments made by relatives during the inspection should be fully investigated by management and actioned as required. Three requirements were made regarding the service being well led. Concerns were also raised regarding governance arrangements and leadership of the home.	• Incidents 08/09/16 – 17/10/16: Medicines 3, Neglect 1, Falls 2, Significant Weight Loss 1, Altercation 2, Sexual Incident 1. • 21/10 - Reports of residents leaving Dunmurry Manor unnoticed. Family members advise South Eastern HSC Trust via e mail. • During this time a resident whose pressure sores had been scored as Grade 2, had their scores suddenly changed to a Grade 4. This extreme change in the score indicated the pressure sores had not been assessed properly the first time.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
13. 24 October 16 Unannounced Estates Inspection - 1 Requirement and 3 Recommendations.		The requirement was regarding the completion of works in relation to the temperature of blended hot water and water pressure at some outlets.	• Incidents 18/10/16 – 24/10/16: Staff Issues 1, Neglect 2, Residents Unaccounted for 1. • HSC Trusts reference problems with record keeping and incident reporting, Care Plans missing basic information, poor staff co-operation with safeguarding investigations and poor staffing levels.
25 October 2016		3 Failure to Comply Notices issued -compliance to be achieved by 04/01/2017. Must manage the home with sufficient care, competence and skill. Must provide services to each patient which reflect their needs and best practice. Must be appropriately staffed by skilled employees. RQIA request Serious Concerns meeting with Runwood. In the meeting a Runwood representative acknowledged the failings of Dunmurry Manor and discussed actions that had and would be undertaken to address the identified concerns.	• Family of Resident A alert RQIA/ South Eastern HSC Trust and media regarding concerns. • HSC Trust officials voicing concerns including poor recording and reporting, noncompliance with SALT/ TVN recommendations, medications and high staff turnover and agency employment. • HSC Trust official suggests that Dunmurry Manor be referred to the PSNI for Institutional Abuse.
November 2016	Dunmurry Manor closed to new admissions		• Concerned families protest outside Dunmurry Manor. • South Eastern HSC Trust issue "Early Alert" to DoH (the Department)

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
December 2016	Manager 8 resigns Manager 9 appointed		• Manager 8 in post 7 weeks. 9th Manager in 2.5 years appointed. The Commissioner receives 2 calls from concerned families and is made aware of whistle blowing. • The Commissioner requested urgent meeting with Minister of Health. • Public Meeting in Balmoral Hotel. COPNI Reps attend • South Eastern HSC Trust, as host Trust, request meetings with Runwood/Belfast HSC Trust • South Eastern HSC Trust contact COPNI with their concerns to notify of Early Alert sent to the Department. Trust Request that two senior members of Runwood staff no longer have input into Dunmurry Manor. • 20/12/16, public meeting about Dunmurry Manor, considerable distress / upset amongst the relatives attending.

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
14. January 2017 RQIA conduct enforcement compliance inspection/ failure to comply with 3 notices issued October 2016, leads to extension of period for compliance on notices to 27/01/2017.		No evidence at the time of the inspection to validate full compliance with the 3 failure to comply notices. However, it is reported that there was evidence of some improvement. Decision was made to extend the compliance date to the maximum legislative timeframe of 90 days. Compliance was therefore required by the 27th January 2017.	• Incidents 25/10/16 – 04/01/17: Meds. 1, Pressure Sores 1, Staff Issues 1, Neglect 2, Falls 2, Environment 1, Altercations 3, Residents Unaccounted 1, Unexplained Injuries 2 • Request for copy of RQIA report by COPNI refused by RQIA (COPNI told it could only access the report when publicly available, 2-3 months later). • Trust Audit report (January 2017) - poor recording, inadequate staffing, slow response times to incidents. • Trusts concern about inadequate delivery of improvement, and leadership within Dunmurry Manor. • RQIA receiving concerns about fluctuating water temperatures, legionella checks, maintenance ordering through HQ in England, and electrics. • Issues with complaints, including a meeting with a family about a serious complaint that was delayed by Runwood for months. • Instances of unsatisfactory care, high weight loss, unexplained injuries for a resident, and a lack of pressure relieving mattresses in Dunmurry Manor. A resident whose Grade 4 pressure sores had been infected with E-Coli passed away - being investigated by the PSNI.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
15. End January 2017 - RQIA conduct enforcement compliance inspection.		RQIA place notice to impose conditions on Dunmurry Manor. The conditions were that admissions were to cease; the provider must ensure that a nurse manager is working in the home on a day to day basis and the provider must ensure that Regulation 29 monthly reports and copies of any other monitoring reports are provided to the RQIA within three working days of the visits/reports having been completed.	• The Commissioner commenced investigation into Dunmurry Manor (15.02.17) • Staff raising concerns regarding cleanliness and hygiene, staffing levels and general care.
16. March 2017 Unannounced Medicines Management Inspection (16.03.17) – 1 requirement and 1 recommendation.	Manager 9 resigns Manager 10 appointed	This inspection report notes that areas for improvement regarding medicines management had been addressed in a largely satisfactory manner, except for the cold storage and the disposal of medicines. The improvements that had taken place were acknowledged and it was emphasised that these needed to be sustained.	• Incidents 28/01/17 – 16/03/17: Medicines 4, Falls 2, Altercations 2, Sexual Incident 1. • Manager 9 resigns after 4 months • HSC Trust staff visit Dunmurry Manor – numerous concerns raised and documented in a Schedule (10.03.17) • Staff feedback to a HSC Trust - Runwood wanting to implement lower staffing levels, staff struggling to dress residents, give meds, perform repositioning and attend to personal care at these levels. • Question posed by HSC Trust officials that the practices in Dunmurry Manor such as poor quality continence pads used constituted 'institutional abuse'.

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
17. May 2017 Unannounced care inspection – 1 requirement and 2 recommendations. 1 stated for the second time.		A care inspection was carried out 4 months after the conditions notice had been served. This reported that there was evidence of improvement in the safe delivery of care. Further improvement was still needed in the effective delivery of care with shortfalls highlighted. It was noted that relatives were generally complimentary however a small group of relatives were negative. The inspection report notes that 4 relatives were spoken to with 3 expressing dissatisfaction - no evidence to validate that actions in two failure to comply notices had been fully met and conditions on the registration of the home remained in place.	
18. End June 2017 Unannounced Care Inspection – No areas for improvement were identified.		A further care inspection was carried out because of an anonymous telephone call and a whistleblowing letter to the RQIA. The inspection set out to investigate possible breaches in the Nursing Home Regulations (Northern Ireland) 2005. One visitor/representative was spoken to. No new areas for improvement were noted in this report. It was however noted that the areas for improvement in the 4th May 2017 report were not reviewed in this inspection.	
19. July 2017 Unannounced Care Inspection – No areas for improvement were identified		This inspection was undertaken following communication from Runwood indicating that they considered Dunmurry Manor to be compliant with the FTC notices. The inspection report concluded that because of the sustained improvement in the areas inspected, the conditions on registration of the home imposed on the 13th April 2017, were removed.	

Chronology / Timeline Of Dunmurry Manor – Managers, Inspection Findings and COPNI Investigation Findings *(continued)*

Date	Dunmurry Manor Management Status	Summary of RQIA Inspection Findings	Summary of COPNI Investigation Findings
20. August 2017 Unannounced Care Inspection – No areas for improvement were identified.		Three weeks later a further care inspection was undertaken because of the forced closure of another Runwood care home. The inspection was carried out to ensure appropriate arrangements were in place for the safety and wellbeing of those patients in Dunmurry Manor.	
21. October 2017 Unannounced Medicines Management Inspection - 1 Requirement relating to the cold storage of medicines was restated.		The recommendation relating to the disposal of medicines had been met. As a result of the inspection the provider also had to comply with the need to review the current systems to ensure that a record of all incoming medicines is maintained.	
22. January 2018 Unannounced Estates Inspection – 2 areas for improvement.		Evidence of good practice was found in relation to the planned refurbishment of interior surface finishes and building services. A previous requirement and three recommendations had been met.	
23. End January 2018 Unannounced Care Inspection – 1 area for improvement.		The most recent inspection at the time of writing this report was a Care inspection on the 29th January 2018, five months since the previous Care inspection. This report concludes that the home is maintaining standards and some areas of good practice are recorded in the report. One area for improvement was highlighted, relating to the need for registered nurses to record any changes to catheter care and management in accordance with best practice and clinical guidelines.	

TOTAL: 23 Inspections in three and a half years
= an average of one inspection every 1.82 months

Approaches to Regulation

RQIA's inspection approach is underpinned by the Better Regulation Commission's principles of good regulation and by the Hampton Principles[23] which state that regulation should be proportionate, transparent, accountable, consistent and targeted.

On the basis of these principles regulators should bear in mind the following:

- Proportionality – Regulators should only intervene when necessary and remedies should be appropriate to the risk posed and costs identified and minimised
- Accountability – Regulators must justify decisions and be subject to public scrutiny
- Consistency – Government rules and standards must be joined up and implemented fairly
- Transparency – Regulators should be open and keep regulations simple and user-friendly
- Targeted – Regulation should be focused on the problem and minimise side effects

The quality standards for health and social care in Northern Ireland were launched in March 2006. These standards were seen as part of a broader framework to raise the quality of health and social care services to the community throughout Northern Ireland.

The standards were established to give health and social care agencies and other organisations a measure against which they can assess themselves and demonstrate improvement; help people who use services and carers to understand what quality of service they are entitled to; help to ensure implementation of the duty that health and social care providers have in respect of human rights and equality of opportunity for the people of Northern Ireland and enable formal assessment of the quality and safety of health and social care services.

Five quality themes make up the standards which are applicable to any health and social care environment whether community, primary, secondary or tertiary care.

The five quality themes are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

It was determined at the time that the standards would be measured by the RQIA. It was envisaged that the RQIA in conjunction with health and social care organisations, people who use services and carers would agree how the standards would be interpreted to assess service quality.

The RQIA provides public assurance about the quality, safety, and availability of health and social care services in Northern Ireland and encourages continuous improvement in those services and safeguards the rights of people who use services.

The RQIA does this through inspection of services; the reports of these inspections are published (after approximately two months) and are public documents. As part of its approach to inspection the RQIA uses information, evidence and intelligence presented to it to inform each inspection.

In 2015 the reporting format of the RQIA changed to include a summary at the beginning of the report which describes whether care is safe, effective and compassionate and whether the service is well led.

Within each inspection report, however, there is the following statement:

> *'It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service... the findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within the report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.'*

Each inspection looks for evidence of quality in the four domains of safe, effective, compassionate and well led care.

- Is care safe? Avoiding and preventing harm to people who use services from the care, treatment and support that is intended to help them
- Is care effective? The right care, at the right time in the right place with the best outcome
- Is care compassionate? People who use services are treated with dignity and respect and should be fully involved in the decisions affecting their treatment, care and support
- Is the service well led? Effective leadership, management and governance which creates a culture focused on the needs and the experiences of people who use the service in order to deliver safe effective and compassionate care

If the care being delivered falls below the standard expected, the RQIA has the ability to take enforcement action.

The RQIA does not currently use an assessment framework to assess each domain. The Commissioner understands that a consultation on changes to inspections and the introduction of an inspection assessment framework was undertaken in 2016 but this does not appear to have yet been implemented. It is anticipated that this would include the use of levels of achievement. This type of assessment framework and rating system approach is a common feature of regulators in England and Scotland.

- The Commissioner is of the view that the implementation of a performance rating system should be introduced and would be of benefit to people using services and their families as it would clearly indicate the quality of the services being delivered.
- The approach to inspection in Northern Ireland is similar in many ways to other regulatory bodies. However, the systems in place in Scotland, England and Wales show some differences and there is some value in considering some of the approaches from these other nations (see table overleaf).

[23] Hampton Principles: Reducing administrative burdens: effective inspection and enforcement http://webarchive.nationalarchives.gov.uk/+/http://www.hm-treasury.gov.uk/media/7/F/bud05hamptonv1.pdf

Regulation and Inspection: England, Scotland, Wales and Northern Ireland

England: Care Quality Commission (CQC)

- Grading system in place. The provider of your care must display the CQC rating in a place where you can see it. They must also include this information on their website and make the latest report on their service available to you.
- The CQC carry out comprehensive inspections and also focused inspections.
- Do not investigate individual complaints.
- The CQC can also hold the provider to account for their failings by issuing simple cautions, issuing fines and prosecuting cases where people are harmed or placed in danger of harm.
- Duty of Candour. The provider of your care must be open and transparent with you about your care and treatment. Should something go wrong, they must tell you what has happened, provide support and apologise.

Wales: Care Inspectorate Wales (CIW)

- The Regulation and Inspection of Social Care (Wales) Act 2016 will change the regulation and inspection of social care in Wales. It will be fully implemented and operational by April 2019.
- No grading system but intends to introduce clear judgements for the public on the quality of the service and the outcomes for people receiving services.
- Do not investigate individual complaints.
- Two types of inspections, full and focused. Focused inspections normally happen when concerns are raised or to follow up on areas of improvement identified at previous inspections.
- Care Inspectorate Wales will have the power to issue fixed penalty notices and more easily hold service providers and responsible individuals to account.
- Duty of Candour.

Scotland: Care Inspectorate

- Grading system in place. The Care Inspectorate awards grades for certain quality themes that have been assessed. These quality themes cover the main areas of a service's work i.e. quality of care and support, quality of environment, quality of staffing, quality of management and leadership.
- Uses lay assessors during inspections - volunteers who have used care services or have helped to care for someone who has used care services.
- Complaints - Anyone can complain to them; people who use the service, their family and friends, carers and staff. The Care Inspectorate will investigate each complaint.
- Duty of Candour.

Northern Ireland: RQIA

- The RQIA carries out inspection of services and the reports of these inspections are published and are public documents. The RQIA will use information, evidence and intelligence presented to it to inform each inspection.
- If the care being delivered falls below the standard expected, the RQIA has the ability to take enforcement action. This does not include financial penalties.
- No grading system.
- Do not investigate individual complaints.

Findings of the investigation in relation to Regulation and Inspection

Regulation and inspection issues and concerns were raised with the Commissioner in interviews with families, staff and HSC Trust officials during the course of the investigation.

The table below is a summary of the investigation findings in relation to the theme of Regulation:

	Theme 5: Regulation and Inspection (RI)
RI1	High volume of inspections carried out between July 2014 and August 2017.
RI2	A failure of responsible bodies to act on findings of poor care.
RI3	Inadequate response to the contravention of regulations.
RI4	Ongoing concerns regarding revisions to the inspection methodology and the progress of implementation of findings from previous reviews (external and internal): • Changes due for implementation in Quarter 4 2015-16 on the introduction of a performance rating system for care homes.
RI5	Insufficient evidence of effective partnership working between responsible bodies.
RI6	Evidence of a lack of clarity with regard to roles and responsibilities and complaints management.
RI7	RQIA Board not aware of ongoing issues of concern in Dunmurry Manor.

Recommendations: Regulation and Inspection

In summary the following recommendations are made in light of the evidence gathered by the Commissioner during the course of this investigation.

R28: Integrated inspections which cover all of the lived experience of residents should be introduced by the RQIA as soon as possible.

R29: A protocol for collaborative partnership working in improving care in a failing care home should be developed and implemented as a matter of urgency by the RQIA and the HSC Trusts. The protocol should address the handling of complaints and the use of intelligence deriving from these to better inform all those with responsibility for the care of older people placed in homes.

R30: RQIA need to review their inspection methodology in order to access reliable and relevant information from residents and their families.

R31: RQIA inspectors must engage effectively with staff, especially permanent staff, in order to glean a more comprehensive view of the home being inspected.

R32: The use of lay assessors/ inspectors in the inspection of care settings for older people should be introduced.

R33: There should be a strict limit to the length of time a home is given to make improvements to bring its service back into full compliance.

R34: The RQIA should implement an inspection regime which includes weekend and night-time inspections for all homes on a more regular basis (and at least once per year), especially where there are indications of problems within a home. This offers an opportunity to reflect on the management of night time and weekend needs when fewer staff may be present and residents may present with more challenging behaviours.

R35: The DoH / RQIA should introduce a performance rating system / a grading system, as is the practice in other jurisdictions of the United Kingdom as soon as possible.

R36: The system of financial penalties should be strengthened and applied rigorously to providers of independent care homes which exhibit persistent or serious breaches of regulations.

R37: The RQIA should have a statutory role in ensuring that complaints are actioned by care providers to the satisfaction of complainants.

4.6 Staff Skills, Competence, Training and Development

Conclusions: Staff Skills, Competence, Training And Development

The evidence gathered during the investigation supports the following conclusions in terms of the staff skills, competence, training and development at Dunmurry Manor;

- Those interviewed reported that there were inadequate numbers of staff to give safe and compassionate care to residents
- The turnover of staff, levels of agency staff and the skills level of the staff were reported consistently as issues in Dunmurry Manor
- The South Eastern HSC Trust was consistently and continually involved in providing training and highlighting skills gaps in Dunmurry Manor
- Dunmurry Manor / Runwood failed to address ongoing issues of staff retention and morale in Dunmurry Manor over a prolonged period
- With the exception of "signing-on" to the "E-learning system", the expected levels of training, development, mentoring and ongoing support were apparently inadequate for care staff in Dunmurry Manor

The shortage of nurse staffing in the NHS and independent sector is well publicised and presents a challenge in many countries. Despite UK governments, over many years, making promises to allocate more resources into nurse training and increasing the nursing workforce to meet increasing demands, the problem of training, recruiting and retaining registered nurses continues.

Professional bodies such as the Royal College of Nurses and others have been campaigning over decades for improved workforce planning and direction from successive governments. Documents and papers have been produced which come to the same conclusions regarding the recruitment and retention of nurses and the crisis which has resulted from increasing demands on the service and inadequate workforce planning.

Legislation and Standards

Health and Social Services, The Nursing Homes Regulations (Northern Ireland) 2005, 20 (1)(c) require the home to ensure those employed receive appraisal, mandatory and other training appropriate to the work they perform, and they are enabled from time to time to obtain training and/or further qualifications appropriate to the work they perform.'

Health and Social Services, The Nursing Homes Regulations (Northern Ireland) 2005, 20(1)(b) the Registered person should *'ensure that the employment of any persons on a temporary basis at the nursing home will not prevent patients from receiving such continuity of nursing as is reasonable to meet their needs.'*

For the purposes of this theme, the following Standards apply;

Standard 38 *'Recruitment of staff'*, states that recruitment should be in line with Department of Health procedures, with two written references linked to the requirements of the job being maintained. Registration status with the NMC, NISCC and any other relevant regulatory body is confirmed.

Standard 39 also insists that staff should be *"trained for their roles and responsibilities,"* with all staff who are newly appointed, agency staff and students required to *"complete a structured orientation and induction and records are retained."*

Standard 40 is titled *'Staff supervision and appraisal'* and refers to the written policy and procedures that detail these arrangements in line with Departmental guidelines. As part of this the policy includes the use of mentorship as part of the induction process and preceptorship of newly qualified registered nursing staff. There must be supervision and support for staff, and staff must have recorded individual, formal supervision according to the home's procedures, with it being most frequent for new staff.

Standard 41, *'The number and ratio of staff on duty at all times meet the care needs of residents'*. Ensure that *'at all times suitably qualified, competent and experienced staff are working at the nursing home in such numbers as are appropriate for the health and welfare of the patients.'* The skill mix should be at least 35% registered nurses and up to 65% care assistants, maintained over 24 hours.

Initial induction must take place within two days of employment commencing, with full induction carried out within three months.

Known Challenges in Nursing across Northern Ireland

The challenges of recruiting and maintaining a stable nursing workforce within the statutory and independent sectors have been increasing over the last four to five years. The complexity of care required for residents in nursing homes is increasing and requires safe, effective and compassionate nursing. Care is now offered to a wider spectrum of specialisms and this brings with it the challenge of recruiting staff with the requisite skills and knowledge.

As the complexity of care increases it places an additional burden on nursing and care staff. Identifying the correct numbers and skills mix of staff required to deliver care within the sector has been on the agenda for some time. In earlier care standards (2003) the RQIA stated (Standard 30) that *"the number and ratio of staff to patients is calculated using a method that is determined by and agreed with the Regulation and Quality Improvement Authority..."* RQIA provided guidance to assisting organisations in calculating appropriate staffing levels, however, this is no longer available.

In 2015 the minimum standards were reviewed and reissued to service providers and the staffing standard was revised to ...*"The number and ratio of staff on duty at all times meet the care needs of residents."* So, the responsibility for determining safe and effective staffing levels lies with the provider and no guidance is now offered to the sector.

While the DoH (previously DHSSPS) has been working for several years in producing guidance for providers to calculate normative staffing levels

in the acute health sector there has been little guidance supporting the independent sector in determining safe and appropriate staffing levels.

Resident Y's daughter stated that staffing levels were 'very poor especially in the evenings.' If she needed assistance from a member of staff she would 'have to go looking' for someone.

- *"Staff are 100% hard working but there are not enough of them."*
- *"There were never enough staff on duty, on any visit I was at or any other member of the family. Never enough staff to go round for the level of need. It was clearly visible when you had to settle residents, finding someone undressing in the hall – we had to find staff to help these people."*
- *"Always got the impression they were choc o bloc in terms of work...witnessed them looking busy and the staff would have said they were. There are such complex needs with the residents and the staff never stopped."*
- *"There were never staff about. At the start it was okay as there weren't that many residents, but as they (residents) came in, not enough staff to cope with it"*
- *"In the first few weeks it was fine, but with the influx of care patients, just not enough staff."*

Staffing issues were frequently discussed during the Commissioner's investigation interviews. Relatives of residents in particular, identified a number of staff related themes including staffing levels, staff culture and staff training.

Some relatives felt that nurse and care staffing levels seemed appropriate and they were satisfied that their relative was receiving a good quality of care.

However, there was evidence in disclosed documents and in interviews that new staff, both permanent and agency, had not been given adequate, or any, inductions. They also stated they did not have assigned mentors to provide advice and guidance.

There is evidence that nurses who were supposed to do handovers did not do any kind of induction. There was one example of a member of staff who had only been working in the home 'for a few days' without receiving an induction themselves being instructed to give another member of staff an induction. Another member of staff was given an induction pack and after 6 weeks was asked to 'just sign it off' with no kind of assessment.

Many witnesses (former staff, Trust staff and relatives) reported concerns regarding the staffing levels and the impact of this on the quality of care provided.

Trust Staff

A HSC Trust staff member attended at the home and described how he spent *"35 minutes trying to get someone who was prepared to speak."* He stated *"you get the feeling they are running away from you. My feeling is they don't really know the patient you want to discuss or they are just unwilling."*

Another HSC Trust member of staff attended the home and sought out the manager. He found the nurse's station and storeroom open and unattended. He was then able to walk through the unit for around 5-10 minutes while looking for staff. He saw residents who *"were being left to their own devices."* It became apparent that a staff meeting was being held and only one staff member remained and she was based in the office.

Other comments made about staffing in interviews are outlined below; the main themes are that the home was inadequately staffed and relied heavily on agency staff. There are a significant number of direct quotes from relatives of residents, former staff of Dunmurry Manor, and staff/officials of HSC Trusts:

- *"they are very obviously understaffed on a Sunday. The staff are all pleasant, very nice, they really are."*
- *"not enough trained nursing staff. They were working on the absolute minimum in my opinion that they could get away with."*
- *"not enough during the day and very few at night."*

Some staff reported their concerns that poor staffing levels had on the quality of patient care they could deliver. One senior staff nurse told us that she reported her concerns regarding staffing levels to RQIA. *"RQIA did look at them and suggested we needed more staff upstairs...it was taking to 2am to do the night medicines."* This theme was noted in other interviews when staff reported medications not being administered on time.

- One relative decided to move her father from Dunmurry Manor because of the poor staffing levels *"There were poor staffing levels so we decided to move father somewhere else. Staff had no time...always rushing about from one place to another. No one had time to stay with dad to feed him, he wasn't clean, clothes were not clean. We found clothes crumpled in the wardrobe."*
- A nurse told one relative: *"This home is very dangerous - there are not enough staff for it to be safe and I want out."*
- Another relative told a manager in Dunmurry Manor. *"You are all running around like headless chickens, there are not enough of you."*

Inadequate staffing levels impacted on relatives in a number of ways. Relatives reported they had to visit their family member every day to make sure they got the care they required, including personal care and assistance with eating and drinking. One relative of a resident told us that they stayed every

evening until 11pm to ensure their father had received all the care he needed before going to sleep. They stated: *"Staffing levels at night were horrendous- there were never enough staff to help with eating. I would go in and help my dad with one hand and someone else with the other."*

The high use of agency staff and staff turnover was a concern to many families and residents. They reported that the use of temporary staff meant that residents were not known to these staff and this impacted on the continuity of care.

- *"Only recently I started to take a day or two off a week visiting as before I felt I needed to be in every day to ensure my wife was being cared for" stated one relative. "Staffing levels were terrible – there was never adequate staff, never any continuity, always agency staff, scarcity of staff, couldn't get anyone to do anything, no one accepts responsibility…Agency on 2-3 times a week and no continuity. Didn't get to know the residents."*
- *"In terms of properly qualified nursing staff they were few and far between… certain staff were wonderful but they never stayed. I didn't like the comings and goings of staff as Mum just got used to someone and then they left."*
- *"Staff were replaced by agency staff – and that is where all the problems in my opinion have come from. No continuity of care - I actually complained to the social worker. Argued with a person on the phone in Dunmurry Manor – who said my dad was not there; tried to speak with a manager; [they were] not available to speak to (happened quite often)…there were not enough trained nursing staff. They were working on the absolute minimum in my opinion that they could get away with."*
- *"There weren't enough nurses. A lot of agency staff made me nervous…I think the people who worked there were lovely but exhausted and overworked."*
- *"A lot of turnover of staff so no one seemed to know what was going on with dad."*

These views on staffing levels were echoed by staff, both agency and permanent staff who were employed in Dunmurry Manor.

- *"It was chaos. I was scared working there – that was why I didn't go back.*
- *"For me there just isn't enough staff to care for all the residents."*
- *"There aren't enough staff"– there is no opportunity for breaks… saw residents who were soaked, food would be cold because of lack of staff."*
- *"Staffing was a real issue… staff nurses were under severe pressure staying on far beyond their shift. The…[regional management] knew about this but was not prepared to deal with staffing issues. When suggestions were made they were always blocked. There was no consistency of staff, no relationship with clients and families….staff were fearful."*
- A HSC Trust manager had concerns about staffing levels and complexity of residents' needs. They said: *"One overarching issue was - no regard given to the complexity of the individuals - just a fill the bed mentality. Too many people with high needs brought in at the same time. Led to resident on resident altercations, not enough staff to deal with the complex needs. Whilst Dunmurry Manor said they met the staffing standards, this did not meet the complex needs of the residents."*

Other HSC Trust managers echoed these concerns regarding staffing levels. This is particularly concerning given that the HSC Trust retains a duty of care to all of its placed residents. Many staff interviewed raised their concerns about the risks associated with unsafe staffing levels and the impact on them personally, as well as on very vulnerable residents.

- *"It was understaffed and no one told me where the fire doors were and the nurse didn't know as he was agency too."*
- *"At one stage a fire alarm went off in the building and no one knew what to do."*
- *"I wasn't aware of any procedure (in relation to Dunmurry Manor being understaffed). I spoke to the agency about it and they advised me to walk out the door if it happened again and they would sort it. Very hard to just walk out the door though when you see the residents and you know they won't get what they are paying for, which is care."*
- *"Staff were suffocated by volume of work (caused some staff to leave)…. hard to give high number of agency staff guidance."*
- *"Care needs there are at very high levels- even for EMI. It is a "unique" home – high dependency residents and lots of wandering residents. Layout of the home does not help- hidden nooks and crannies."*
- "After a time, people would be *really exhausted and some said 'that was it'."*
- *"Retention of staff was a big issue and it destabilised the home and it made it very difficult to keep, hard to keep consistency. It was difficult for a strange staff member to come in and write a care plan on someone they didn't know."*
- *"The ratio of staff - at the start it was fine with lower numbers of residents, as the number went up the ratio went up too. At the time it wasn't ok, we weren't equipped to deal with the needs that we had."*
- *"When we had 20 residents I didn't feel there was enough staff. I raised concerns about it with the number of falls we were having and the level of supervision we could provide as the unit was so big."*
- *"Staff were very busy and didn't get breaks at times- the needs of residents always came first, staff rarely finished shifts on time…one shift I did lasted 24 hours!"*
- *"I felt I was doing my best but not enough staff. For the needs of the residents would have needed two nursing staff to work with them."*
- *"There was always people coming for interviews and they (Runwood) always made promises, but nobody stayed."*
- *"About three months in – every single staff nurse seemed to be leaving, and they were all brilliant. They just couldn't take it."*

Staff Culture

Organisational culture can have a significant impact on the experiences of residents, relatives and staff, particularly in relation to the quality of care residents experience and the relationships between different groups within any care environment.

The issue of culture and staffing can normally be addressed by strong management, which is difficult to establish if there are ten different managers since the opening of Dunmurry Manor and within the space

of three years. The implications of this are discussed in further detail in chapter seven.

The issue of culture was one frequently reported by staff during interviews. Agency nurses reported feeling unwelcomed, especially with care staff who appeared reluctant to take direction from a registered nurse. Some registered nurses who had worked at Dunmurry Manor gave evidence regarding the culture of the staff team there;

- *"There was a bad atmosphere among the staff – seemed to be a power struggle with the care assistants not being happy with agency staff being there. Staff were also making fun of the Manager."*
- *"The staff weren't united…the care assistants did not like us…they did what they liked. It was not a happy experience. We were not informed who the Nurse in Charge was. I wanted to know who the residents were and to work with the care assistants but they did not want to work with us."*
- *"I could feel the vibes and the atmosphere in the home that they were not happy. That would affect the care you give the residents. That is a big factor in the home if the staff are not happy, the care is severely affected."*
- *"Care assistants did not like us"… there was a "tense atmosphere."*
- *"Care assistants did not want to work with the nurses, was scary as we didn't know the residents."*
- *"There was an atmosphere. I have never come across it before."*
- Care assistants were *"doing what they liked'…it was entirely run by care assistants".*
- HSC Trust staff had noted the power which care staff had within Dunmurry Manor and raised this with the manager…*"the power base in the home is held by care staff - this will be very difficult for a manager to deal with."*

Findings of the investigation in relation to Staff Skills, Competence, Training and Development

The table below is a summary of the investigation findings in relation to the staffing, skills, training and staffing levels to care for residents of Dunmurry Manor:

	Theme 6: Staff Skills, Competence, Training and Development (ST)
ST 1	Evidence of poor and inadequate staffing levels, essential skills and training including staff being expected to work outside of their skills and competencies and staff inability to take breaks
ST 2	High level of staff turnover
ST 3	Over-reliance and continued use of agency staff and additional support from the South Eastern HSC Trust leading to poor continuity of care[24]
ST 4	Evidence of inadequate handover reports, lack of staff induction or no induction reported by workers despite policies and procedures reported as being in place
ST 5	Mandatory training (including for kitchen staff) not completed and updated
ST 6	Lack of a consistent approach to keeping adequate training records and continuous professional development for employees

[24] Over-reliance on additional support staff provided by HSC Trust who were counted within the regular work rota rather than as an extra source of advice and support within the home. This perpetuated the staffing issues.

Recommendations: Staff Skills, Competence, Training and Development

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.

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.

R40: The RQIA should collaborate with the CNO in this work and revise the minimum nurse staffing standard No 41 to give more clarity to the independent sector on levels of nurse staffing which are required to deliver safe, effective and compassionate care.

R41: A high level of staff turnover and use of agency should be considered a "red flag" issue for commissioners of care and the RQIA. 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.

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.

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.

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.

4.7 Management and Leadership at Dunmurry Manor

Conclusions: Management And Leadership

The evidence gathered during the investigation supports the following conclusions in terms of the management and leadership in Dunmurry Manor:

- There was a lack of cohesive and effective management and leadership of Dunmurry Manor since it opened in July 2014
- Families, agency staff, former staff and HSC Trust staff all had concerns and made efforts to highlight their concerns to both management in Dunmurry Manor and to Runwood senior management
- There was clear control of the information reported by Northern Ireland management to the Head Office of Runwood (based in England) that did not portray an accurate picture of the performance of Dunmurry Manor. There appeared to be no honest reporting of the reality of the circumstances in Dunmurry Manor on either a Northern Ireland or a corporate level risk register
- It was given in evidence that no exit interviews took place of staff leaving Dunmurry Manor
- Runwood Homes gave no evidence of attempts to understand why managers were leaving so rapidly, in quick succession

In recent years the media has often voiced concerns regarding the perceived lack of leadership within the health and social care system in Northern Ireland. They view failures in the system as being directly related to a lack of strong leadership and management of our health care facilities and funding. The media creates a perception that things were better "back in the day" when someone in authority took charge and ensured high standards of care were maintained. This cannot be realistically compared to the current complexities of health and social care today.

Healthcare leaders today have a much wider portfolio of roles and responsibilities within both their clinical and governance agendas. Increased demands of corporate governance, business planning and contracts negotiation, commissioning of outsourced services and budget control are all essential management functions. Throughout all the complexities of the modern health service strong leadership and management is vital and the changes required to manage this complex environment and deliver the highest standards of clinical excellence rely on the strength of health service leaders.

The integrated health care system in Northern Ireland is extremely complex to navigate for the general public and many older people seek the advocacy support of the Commissioner for Older People for Northern Ireland to make and resolve complaints. The previous Commissioner made a recommendation in the 2014 Changing the Culture of Care report that complaints processes should be more accessible and visible for service users, relatives and staff.

In nursing homes in the independent care sector, high quality nurse manager leadership is the single most important factor influencing the quality of care being offered, developing and maintaining a safe, effective and compassionate service. With the increasing reduction in secondary care beds and dependency on the independent care sector to deliver more complex care primarily for older people, high quality leadership is vital in this area.

The importance of effective leadership and management was clearly recognised by all those who were interviewed by the Commissioner. It was a recurring theme throughout interviews and was the most frequently mentioned area of concern. While it is recognised that management and leadership are two different concepts, those interviewed used the terms interchangeably, hence both are reported in this section.

Legislation and Standards

Nursing Home Standards, **Standard 35** - Governance, any absence of the registered manager of more than one month is notified to the RQIA and arrangements for managing the home in the absence of the registered manager are approved by the RQIA.

Articles 12 to 22 of the HPSS[25] (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 deal with registration and should be read in conjunction with this section. A home must have a Statement of Purpose and an Operational Policy.

The **Statement of Purpose** defines what services and facilities the home will provide whilst the Operational Policy describes how they will be provided. An individual who intends to carry on a home must be registered with the RQIA, and is referred to as the *"Registered Person"*.

An organisation that intends to operate a nursing home is required to nominate one person to be registered on behalf of the organisation. The manager of the home must be registered and is referred to as the *"registered manager"*. The registered person may also be the registered manager. Those applying for registration as the registered person and/or the registered manager must meet the relevant criteria for fitness of these positions.

Furthermore part two of the Statement of Purpose requires that the home has an Operational Policy in place which includes (but is not limited to) the following:

- The arrangements in place to ensure the fitness of persons to work at the home
- The arrangements in place to ensure the adequacy of numbers of persons working in the home
- Admission arrangements for residents, including the residents' guide
- The arrangements for safeguarding
- The arrangements in place for promoting the health and well-being, and spiritual needs of the resident
- The arrangements for the training and development of people who work in the home;
- The care planning process
- The arrangements for securing health and social care services
- The arrangements for the management and control of the home

[25] Health and Personal Social Services [Order]

The RQIA has responsibility for assessing and ensuring compliance with registration of managers and registered persons, with these individuals having to make their applications to the RQIA. They are also responsible for ensuring a home has a correct operational policy.

The information provided to the investigation team demonstrates failures in all of these policy areas. The management and leadership within Dunmurry Manor remained a matter of concern over many months of the time period examined.

An anonymised case study is outlined below for the purposes of outlining the lived experience of the residents of Dunmurry Manor of issues involving management and leadership in Dunmurry Manor:

Resident H (Res H), aged 76, was cared for by family at home for around ten years. Res H had a carer's package which included four visits a day but it became increasingly difficult for the relatives to manage Res H's care and Res H was to be placed in Dunmurry Manor for the family to get some respite for several weeks. Res H stayed in intermediate care for around three weeks before moving to Dunmurry Manor. Res H had some mobility problems, was doubly incontinent and speech was impaired.

Issues/ Experience

Res H's relative gradually became aware of concerns. They noticed Res H's clothes were missing and glasses broken. Res H's care plan indicated that they should be showered three times weekly and teeth cleaned every day. Res H's relative has noticed that Res H appeared unkempt, teeth were not clean and on one occasion one hairbrush was being used for all the residents.

Res H's relative found Res H saturated in urine on numerous occasions, through their clothes and onto the chair. Res H has limited mobility and speech and is unable to ask to be moved. When Res H's relative raised this concern they were told Res H would be changed and put to bed. It was only 7.30p.m. and Res H normally sleeps through until 9 a.m.

When Res H's relative sought a meeting with management to discuss these issues the member of management was an hour late and then informed him he had only 15 minutes to discuss the issues raised. *"So many people that supposedly manage, honestly cannot tell you how many people I met. So many issues and I had to meet with so many managers to try and clear those up."*

Res H's relative describes meeting management around eight times in ten months but no longer has *"faith"* anything will be done. They recounted one instance when they *"met another girl who was an assistant manager about concerns but she told me she wasn't qualified and was leaving the next week."* Res H's relative described a *"culture of silence"* where nobody took

responsibility for the issues raised and despite repeated concerns communicated to staff *"nothing ever changes."*

Res H's relative added *"the home could be a good home if they had decent management – it's a rudderless ship – I couldn't count the managers in the time we have been dealing with it." "My whole concern is with management – if they would get involved. I have never seen a manager getting involved with residents, staff or patients… manager seems to be an anonymous person."*

Concerns and complaints about the management of Dunmurry Manor were among the most frequently mentioned issues for the investigation. High levels of frustration were expressed by relatives of residents at the failure of adequate management throughout the period investigated. Witnesses told the investigation team that:

- *"There was too much to be fixed by one person. I felt like I was drowning."* (former manager)
- *"The company focus was to fill beds. We were told to do this even if we had to use agency staff to do so. I said this was not appropriate as then there was no continuity of care and they don't care about paperwork. I was told to "just do it" from (HQ) management."*
- One manager stated: *"Recruitment had not been done for a long time so it had reached crisis point when I arrived. Looking back over the duty rota there never had been consistent staff and a good skills mix."*
- Another manager told us: *"Staff came to me directly where they had concerns. I tried to reassure the staff and spent a lot of time trying to persuade people not to leave…constant battle…didn't know what the next day would bring…they were working so hard and we were really trying to move the home forward."*

While residents and relatives recognised that it takes time for any new facility to be established and put in place the necessary protocols and procedures, many reported concerns regarding the organisation's ability to respond to issues raised, take remedial action and overall accountability for things that had gone wrong.

- *"They were always saying they were very busy, but there was no leadership – no one is saying standards aren't good enough"*
- The home has *'potential to be brilliant with proper leadership'*
- When asked if they felt management dealt with incidents and accidents quickly and openly a member of Dunmurry Manor staff stated: *"No I don't think so. I think if they had have done, they wouldn't have the volume and level of complaints they had"*

Former staff of Dunmurry Manor at all levels raised issues of not being listened to and the lack of accountability of management there.

- *"Like no matter what you said, you'd be better off talking to that wall. Nothing was followed up … or it was a case of I'll get back to you just trying to palm you off. I got to the stage where I thought, what's the point no one listens."*

Another former staff member found his complaints or issues were rarely dealt with. He raised concerns, particularly around risk management and fire safety and was concerned that there was a lack of accountability and leadership in dealing with them. *"To get things done it felt like banging my head off a brick wall…"* He started to take photographs of environmental issues of concern but was told to delete them by senior management, however he refused to do so. He resigned when he felt that despite his best efforts he was not being listened to and remedial action was not being taken to rectify serious issues.

Turnover of managers and impact on the home

Dunmurry Manor opened to residents in July 2014 and over the three and a half year period under investigation there have been ten managers in post. Relatives found this rapid turnover of managers very frustrating. Staff and relatives believed that this level of turnover of managers was excessive in the independent sector and had a detrimental effect on the quality of the care given to residents and to staff performance and morale.

- *"It is ridiculous the number of managers…you raise something with someone and then they were away…"*
- *"The constant changes in management was not good for staff morale"*
- *"Constant changes in management, staff did not have direction"*

From 2014-2017, as each new manager was appointed, relatives thought that they would make a difference and solve the long-standing problems in the home. The managers came with a desire to make improvements and relatives reported feeling optimistic with each new appointment.

- *"I liked (the new manager)…he gave me confidence that he was going to make a difference. He seemed to hit a brick wall against everything he wanted to bring in."*

Staff within Dunmurry Manor found it difficult to cope with the constant changes in managers and their deputies. This lack of continuity of management and leadership caused uncertainty and lack of stability for the home.

- For a time one staff member reported that they *"didn't even know who was the manager … two managers in one week."*
- Another staff member told the investigation, *"If nothing changes this makes me worried. Leadership and effective management would get rid of a lot of the problems. It has never been there. Why has no manager stayed? Senior Management cannot even support their own regional team- the (member of management) left under a cloud of ill will. (A member of senior management) is apportioning blame unfairly- it is not all about one person being wrong. All have to be working together."*
- Another staff member noted…*"a lack of leadership in the home* has *led to inconsistency in nursing. The managers were not able to embed or given enough support to make positive changes. Nurses weren't going to put up with that. There are things I would like to say but I can't."*

Senior staff from the HSC Trusts reported similar concerns regarding the turnover of managers and lack of leadership in Dunmurry Manor.

- *"The turnover of managers and staff -it is like a "roundabout"*
- *"A good manager is worth their weight in gold"*
- *"Managers in Dunmurry Manor never stood a chance"* suggested one HSC Trust employee
- *"If [the manager] had been given the right support they would have turned it around….they weren't given the freedom and handed in their notice"*

New managers felt particularly vulnerable and were left with minimal support and advice when appointed to the home. They began employment in Dunmurry Manor where there were already serious failings and issues which had not been adequately dealt with or resolved. The lack of a comprehensive induction into the home added further to their frustration and ability to make a success of managing it.

- *"There were on-going staffing issues already in place – there was a shortage of nurses, staff felt like they hadn't been supported or had sufficient training. I think staff were trying their best but they didn't have the necessary experience. There were a number of nurses who were on their first job"*
- *"The lack of management/continuity means you are left to fend for yourself and have to make own decisions 98% of the time, but will still get grief for them."*
- *"I would raise concerns at monthly management meetings – under AOB - told we were getting support and to get on with it"*
- *"It was a very sickening feeling that you could not make it work no matter how hard you tried. I just felt sick to the pit of my stomach every day I went in"*
- *Retention of staff was a big issue and it destabilized the home and it made it very difficult to keep, had to keep consistency. It was difficult for a strange staff member to come in and write a care plan for someone they didn't know"*
- *"The whole system was a mess – where to start? Impossible… didn't have the resources"*
- *"I think the managers were the "fall guys" – they were not given enough support. The senior manager…could have done more for them. Seeking to make Dunmurry Manor a centre of excellence. I know managers were left under a lot of stress"*

Turnover of managers and registration status of managers in Dunmurry Manor since opening in July 2014:

Date	Manager	Applied to RQIA to become registered manager	Registered; Yes / No
July 2014	Manager 1	Yes	Approved, then application withdrawn
Sept 2014	Manager 2	Yes	No
Jan 2015	Manager 3 (Acting)	No	No
Aug 2015	Manager 4	No	No
Nov 2015	Manager 5	No	No
Feb 2016	Manager 6	Yes	Yes
Aug 2016	Manager 7 (Acting)	No	No
Oct 2016	Manager 8	No	No
Dec 2016	Manager 9 (acting)	No	No
April 2017	Manager 10	(Not requested in disclosure – documents up until February 2017)	

Until late 2016 the *"registered individual" for Runwood in Northern Ireland was based in the organisations headquarters in England. A regionally-based operations manager was then registered by the RQIA as a "fit and proper person"* to become the registered individual for the Runwood Homes that were based in Northern Ireland.

Every home should have a local registered manager in line with the regulations. It is concerning that the previous table highlights that the majority of managers (cited in RQIA inspection reports) were never registered as the manager for Dunmurry Manor. In some cases, a number of managers did not ever apply for registered manager status at Dunmurry Manor. There did not appear to be any adverse consequences for the home in respect of the overt and continuing breach of these regulations.

Regional Senior Management

The Commissioner has noted the frequent references to Runwoods senior management by all of those interviewed during the course of this investigation. Many relatives and staff referred to the influence and behaviour of senior management within the home and how it impacted negatively on their overall experience.

Staff found the culture of blame and harassment promoted by senior management to be difficult to deal with. Many reported management shouting at staff and blaming them, and not taking corporate responsibility when things went wrong. They felt that no matter how hard they tried to carry out their duties it was never enough. Others reported that staff resigned due to the behaviour of senior management.

Comments made by staff included the following:

- *"I got very little input from (member of senior management); on the days where he was in the home, he would go through it like … and would pick out very petty things to complain about when staff were against the wall and staff trying their best."*
- *"I had concerns about (member of senior management) and his lack of ability to deal with issues, his treatment of the staff: continued to try to finger point rather than look at himself."*

It was clear from those interviewed that former staff found the controlling behaviour of senior management to be stifling and prevented them from carrying out their roles effectively. Controls on the purchase of equipment and disposables for staff to do their job was a constant frustration expressed by former staff.

- Another reported …*"put orders in and never turned up or head office declined"* This was frequently in relation to continence products and personal protective equipment.
- *"Dunmurry Manor didn't manage its own budget. If you put in your order you weren't always guaranteed to get what you wanted, at times we needed more pads and cleaning materials, wouldn't have got what was wanted"*
- Another manager said she ignored the strict budget…*"I didn't adhere to it and I double ordered…if we had adhered to it we would have run out"*

A number of former staff said that they got so frustrated with the behaviour of the senior management and the negative impact on Dunmurry Manor that they contacted the RQIA to report their concerns. One former staff member gave evidence to the investigation that he contacted the RQIA in October 2016, as he felt he had no option because of frequent changes in management and the mismanagement of the home. He spoke to an inspector in person and by phone. When senior management discovered this, he got *'yelled at'* by them.

Another former staff member gave evidence that they e-mailed the RQIA regarding their concerns about the senior management.

Staff relayed concerns over the controlling and threatening nature of senior management. They gave examples where if they refused to do overtime to cover the home they would be threatened and told they would report them to the NMC and get their *"PINS removed"*. A senior manager reportedly said to one nurse: *"I am a very powerful man' and 'If you want to work in this industry you'd better not cross me."*

Senior Managers in the South Eastern HSC Trust reported similar concerns. *"(Member of senior management) promised you wonders but I had big concerns about his influence …nothing had been carried through that had been promised."*

As time went on the South Eastern HSC Trust became increasingly concerned about the performance of Dunmurry Manor and convened a serious concerns meeting on 21st October 2016 with Runwood senior management to suspend further admissions to Dunmurry Manor. At that meeting, the South Eastern HSC Trust requested that two of the senior management team of Runwood should no longer be involved in the management of Dunmurry Manor.

South Eastern HSC Trust advised RQIA of this decision. One senior manager from the South Eastern HSC Trust advised the Commissioner that RQIA's response to this was that they did not think there was any problem with the regional manager. The request by the South Eastern HSC Trust was taken to the Board of Runwood and, after investigation, was not upheld. The South Eastern HSC Trust expressed that they felt the contract between them and Runwood provided no other mechanisms or sanctions in terms of their concerns about Runwood personnel.

Findings of the investigation in relation to Management and Leadership

A number of key themes emerged during interviews under this topic; they were: changes in and turnover of managers in Dunmurry Manor, the level of nurse / manager presence *"on the floor"* of Dunmurry Manor and regional senior management. These are reported in detail in this section. The table below is a summary of the investigation findings in relation to the management and leadership of Dunmurry Manor:

	Theme 7: Management and Leadership (ML)
ML1	High level of turnover and gaps in registered managers leading to prolonged inconsistencies in management and leadership and poor delivery of care.
ML2	Concerns raised regarding the lack of consistent and coherent management and leadership, including at night and weekends.
ML3	Despite a range of policies and procedures reported by Runwood Homes Ltd as being in place, adherence to these was not evidenced in the management of the home.
ML4	Concerns over senior management role and influence on the operational running of the home.
ML5	References to a 'Blame Culture' within senior management that affected management and staff negatively.
ML6	Staff records including rotas and human resources files not being maintained correctly, including Access NI and NMC checks and vetting.

Recommendations: Management and Leadership

R45: The RQIA should require managers leaving employment with a home to provide them with an exit statement, within a defined timeframe, to enable them to identify patterns or issues which should trigger an inspection. Exit statements would be treated in confidence (and not available to the employer).

R46: Any reports of inappropriate behaviour by senior managers in the 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".

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.[26]

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).

[26] This recommendation is a reiteration of the previous Commissioner's call for reform in support for Whistleblowers, made in Changing the Culture of Care 2014

4.8 Complaints And Communication

Conclusions: Complaints And Communication

The evidence gathered during the investigation supports the following conclusions in terms of complaints and communication:

- Dunmurry Manor could not consistently meet the provision in the nursing home standards that all complaints should be investigated within 28 days, the result of this being that Runwood was not meeting its contractual obligations with the HSC Trusts
- There was a lack of commitment by Dunmurry Manor to progressing complaints quickly, demonstrated by delays in setting up meetings with families or giving them information
- Poor record keeping within Dunmurry Manor hampered the progression of some complaints, making the process take longer, or halting progress altogether
- Families reported to the Commissioner that they felt unsupported, that their input was not valued and that they were not given feedback
- As referred to in section 4.1 of this report, the lack of consistency about what should be designated as an Adult Safeguarding incident, and what should be designated a quality monitoring issue, led to some serious incidents not being fully investigated at the appropriate level (by Dunmurry Manor and the HSC Trusts).
- Some of the RAs (Runwood, the RQIA and the HSC Trusts) were not aware of all the complaints that had been made to each other. There was no centralised source or database to collate all complaints
- There was no evidence of lessons being learned from complaints – either as an early warning system for issues in the home, or to inform inspections. The ability to do this was further hampered by the lack of complete and accurate records in some cases and even the lack of a complaints book
- The Commissioner notes the Northern Ireland Public Services Ombudsman is undertaking research into understanding complaints handling in Northern Ireland and is hopeful that this work will lead to the publication of guidelines or other statutory good practice which will improve complaints handling in the care sector in Northern Ireland.

Through legal and advocacy casework, the Commissioner's office has had extensive experience of the importance of effective complaints processes in care homes. Poorly handled complaints processes can lead to resentment between parties and feelings of helplessness if older people or their families feel that their complaints are not being listened to, or they do not receive adequate feedback. The evidence provided to the Commissioner shows that some families who had made serious complaints about the care given to their relatives in Dunmurry Manor, were not taken seriously, found it difficult to get their complaints addressed and were frustrated by the process. On occasions complaints were clearly not handled in a way that met the requirements of the minimum standards.

Legislation and Standards

Nursing Home Minimum Standards (2015) – Standard 16, 'All complaints are taken seriously and dealt with promptly and effectively'. This standard states that complaints should be investigated and responded to within 28 days and when this is not possible, complainants are kept informed of any delays. Records must be kept of all complaints and they must include details and communications with complainants.

A number of anonymised case studies are presented below to highlight the experiences of complaints and communication from residents families:

Resident X

Resident X (Res X) 86 years old and had been living with dementia after being diagnosed in 2012. They had been living with one of their children after a move from another care home but was at risk of wandering and falling at night. Res X was not on any medication but suffered from recurrent urinary tract infections and needed a daily personal care regime to be carefully followed.

Res X experience was just after admission to the residential unit at Dunmurry Manor. Res X's family first raised a concern after four days when they noticed Res X had not been washed or showered. This was particularly worrying given the history of urinary tract infections and specific daily personal care needs which had been shared with the home before placement. On 18th November 2014, the family were asked not to visit for a few days to give Res X *"a chance to settle-in properly"*.

3 days later, Res X suffered a fall and the family were also advised that they had a UTI. Nursing staff had not called the doctor to see Res X. When Res X's children arrived to visit that evening, they found Res X lying in a wet bed, in the dark, with 3 trays of uneaten food beside them. The family believed Res X was wearing the same clothes from 18th November 2014. They had to insist for the doctor to be called and oxygen to be provided to Res X.

The GP attended and called for an ambulance. On admission to hospital Res X was unconscious and never regained consciousness. Res X's dentures were encrusted and Res X was unwashed. Res X was diagnosed with pneumonia, a urinary tract infection, severe dehydration and sepsis. Res X died three days later.

Res X's family brought a complaint to the home manager however there were no care records available and the family did not feel that they were being taken seriously. It was only after Res X's family sent a detailed letter to the RQIA, that senior management at Runwood appeared willing to investigate the matter further. Unfortunately, a subsequent review showed that no care records or documentation had been generated or maintained in relation to Res X.

No investigation was therefore able to be conducted meaning that the complaint could not be dealt with fully and Res X's family's questions remain unanswered.

Resident B

Resident B (Res B) was admitted to LVH at GP's request due to concerns about bruising, rapid weight loss, and general deterioration (mental and physical)– family advised not to return their relative to Dunmurry Manor. Moved to another home and died within three days.

Res B was 92 years old and had been diagnosed with early stage Lewy Body dementia. Res B had lived in sheltered accommodation for almost 25 years with a domiciliary care package before suffering a fall and being admitted to hospital and then rehabilitation. The family say that Res B understood them and was able to communicate. Res B had become physically frail and required assistance to walk and undress.

Very early on, Res B told the family that they did not feel safe. Res B spoke of a particular fear of night-time because male residents would come into the room, expose themselves, open cupboards and sit on the chair and bed. Res B said that one man sat on their feet whilst in the bed. Staff denied that this had happened and said that Res B was confused.

Res B was primarily bedbound and felt isolated in the room. If family did not assist with feeding, they did not believe Res B would have been fed. The family felt that their concerns were downplayed, requests for meetings were ignored and when a care meeting finally took place, no records or documentation was provided.

Res B's family raised concerns over the standard of personal care and lack of assistance with feeding. An infected toe was not noticed for over 2 weeks and a private podiatrist had to be brought in by the family. Two lesions on Res B's sacrum were not noticed until admitted to hospital.

The family felt they had no choice but to install a covert camera as they believed their concerns were ignored or downplayed. When they did raise concerns about male residents entering their relative's room they were told that staff *'didn't have eyes in the back of their heads.'* The family felt that rather than being dealt with as a complaint the behaviour was *'normalised as acceptable behaviour because of the nature of the unit.'*

Res B had unexplained bruises on the forearms – it looked like someone had tried to pull Res B up. Staff could not explain when they had occurred. Family members produced pictures of their relative's bruising. The immediate response was that Res B must be *'hitting their arms off the trolley.'* The family were skeptical about this response as Res B had previously used the same trolley in hospital but never suffered bruises. The family was informed that their complaint would be referred as a safeguarding issue but they never heard anything more.

No one apologised to the family for any of the concerns and complaints raised. Family members said they *'did not think they (Runwood and Dunmurry Manor) wanted to be bothered'* dealing with incidents quickly and were not provided with the complaints policy.

Resident B *(continued)*

Res B's relatives also contacted RQIA who said they had logged it but they did not say what to do next and did not get back in touch with the relatives.

As of May 2018 (nearly 18 months later) the family's complaint against Dunmurry Manor is ongoing.

A recurring theme from submitted evidence is that families made complaints, a complaints process would be initiated, but then nothing more appeared to be done, or families received no update on what was being done to progress their complaint. One family member in a concern raised with the RQIA cited a *"nightmare of complaints that appear to be listened to but nothing is done."* Even establishing communication with Dunmurry Manor could be difficult. After a long running failure to hold a meeting with a family member concerning a safeguarding incident, a HSC Trust official stated in an email to Dunmurry Manor that this failure was *"derisory and contemptible ."*

A former staff member said in general complaints were not dealt with as quickly as they could have been, and *'little things'* (the example was given of carpets being odorous) could become much *'bigger things'* if not rectified as early as possible, and were upsetting for staff and residents.

There were a number of examples of issues with records and the accurate and timely recording of events in Dunmurry Manor which prevented effective investigations into safeguarding issues. Correspondence from Runwood and the RQIA details that the RQIA investigated a complaint about the death of a family member where the complaints procedure was not adhered to. In this case there had been a lack of timely engagement and response as well as a lack of proper record keeping of meetings, under a complaints governance system which required improvement.

An HSC Trust decision to close an adult protection investigation, into an allegation that a resident was manhandled within the home, noted that there were no daily recordings for the resident, and nothing on the file for the resident at all beyond contact and information details. The employee in question had left, so due to the *"lack of recording, lack of available staff member to give statements, failure to report to Trust Adult Safeguarding for investigation,"* the HSC Trust could not be certain the families' interpretation was correct. Lack of accurate recording and failure to follow HSC Trust procedure for potential Adult Safeguarding cases and failure to adhere to Runwood complaints procedure were identified by this HSC Trust as key issues.

Dunmurry Manor was unable to provide complete information to HSC Trusts

to conduct safeguarding investigations. All HSC Trusts have a statutory duty to monitor and review the care of their placed residents in Dunmurry Manor. However, it is clear that any safeguarding investigation by the HSC Trust would have been incomplete or inadequate without the relevant information being available. Despite this, there is no evidence that the HSC Trusts used the powers available to them when they could have, and in fact only discussed taking action after Dunmurry Manor was in failure to comply.

There appear to have also been problems with the usage of correct procedures to report complaints to HSC Trusts and other bodies. A former staff member in one of the interviews recalled a staff member from one of the HSC Trusts calling a senior employee of Dunmurry Manor a *"liar."* This member of staff said *"I don't believe the reports that had been put to the Trust were comprehensive… inconsistencies in reports dependent on who wrote them…sometimes the information wasn't there – or sometimes the reports didn't correspond with what had been sent before."* One of the former managers of Dunmurry Manor recounts that accident books used were not kept as the official accident record of what had happened, which is a legal requirement.

Despite the problems being discussed by officials from different RAs, reflection of these issues in RQIA inspection reports is mixed. The 21st October 2015 Report states that inspectors were unable to evidence the action taken against complaints. The 24th June 2016 inspection reviewed the complaints record, and the report stated that the management of complaints was in accordance with Regulation 24, outlining that patients and representatives confirmed when they raised a concern or query *"they were taken seriously and their concern was addressed appropriately."*

In contrast, the 17th October 2016 inspection report found that complaints were not always managed in accordance with Regulation 24. Not all complaints were recorded and evidence was lacking in respect of communication with complainants, the result of investigations and actions taken. Overall, the inspection reports do not reflect the scale of complaints which were provided in evidence to the Commissioner, both from witnesses and in the documentary evidence submitted by the RQIA. In reality, from soon after Dunmurry Manor opened, they were receiving complaints from family members and former staff that reflected a wide variety of the problems in the home which highlighted inadequacies with the complaints process.

Family Experience

There is a consistent series of reports from residents' families, both in interviews to the Commissioner and to RAs, that documentation, meetings and investigations into complaints either took a long time to happen or did not happen at all. One family member described a long series of complaints, including a serious complaint about a pressure sore that was not dealt with appropriately. They said they "*felt like it wasn't dealt with no matter what you raised."* There was no contact to the family from Dunmurry Manor, or the RQIA (although the family had also raised the issue with them).[28]

[28] This echoes one of the findings of the recent Inquiry into Hyponatraemia-related Deaths, where institutions were slow to respond and families felt they were not receiving sufficient information.

The way complaints were dealt with proved upsetting to some families, both in terms of the tone taken, and the lack of resolution. This included, in some cases, families being encouraged not to complain, this being directly opposed to good practice recommendations. A family member said the *"overall experience of raising a concern with Dunmurry Manor, was worrying, stressful and troublesome."* One relates their family member being found in a chair dehydrated and constipated - staff *"never apologised. I was made to feel like I was making a big deal. They never did anything."* Another said that *"I complained to (Manager) about my father and was told to go outside and calm down."* Another family member said that they *"found when families make a complaint, almost as if Dunmurry Manor closes ranks, communication with the family is ceased."*

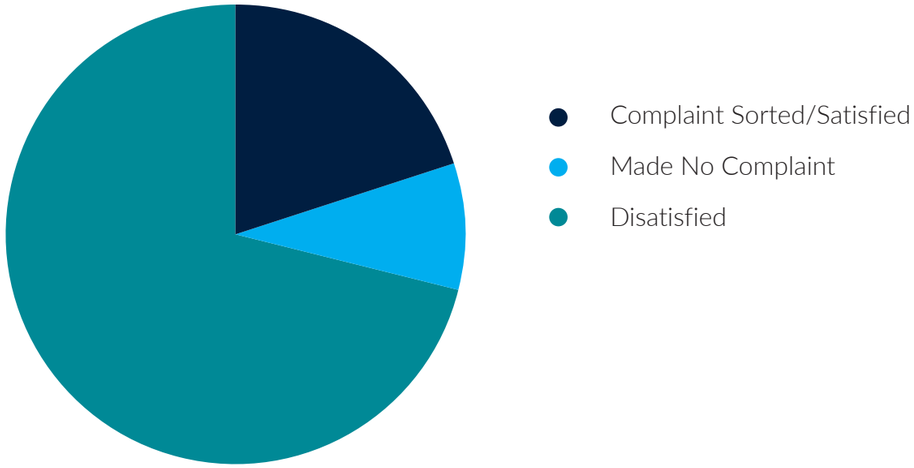
This point was reflected by the experience of another family member who called the process of an investigation into a serious sexual assault as *"an absolute joke"*, where Runwood and staff had been uncooperative, and a meeting took around six months to happen. One family member stated, *"I don't have any faith that anything will be done……If you are ever able to do anything with Runwood Homes it's a miracle because they are a law onto themselves."* The Commissioner recognises that involvement of families and relatives throughout the complaints process is vital. This resonates with the words of the Chairman of the Hyponatraemia Inquiry[29] when he stated that *"shortcomings in communication fuel suspicion"*. This was never more true than in the cases of families' experiences in Dunmurry Manor.

Some families interviewed expressed concern about the failure of management of Dunmurry Manor to prioritise the handling of complaints. One commented that *"I do not think managers were given a chance to learn from their mistakes. One thing was leading to another - a buildup. One of the Managers was not experienced enough to take on a care home - not experienced enough in dealing with complaints."* Another said that *"Managers just paid lip service to be honest. They told you what you wanted to hear and no follow up…experience of raising a concern was horrendous…the way older people are treated is a disgrace. It is criminal."*

Families also described to the Commissioner how they were confused about the role of the RQIA and what their remit was in the complaints process. Families expressed surprise when told by the RQIA that their complaints were *'nothing to do with them'*. One family member said *"in hindsight you don't know their role, I'm still confused as to their role."* There were instances given in evidence of the RQIA also being slow to respond to communications from families.

[29] *The Inquiry into Hyponatraemia-related Deaths: Report*, January 2018

Familes Interviewed by COPNI - Complaints to Dunmurry Manor

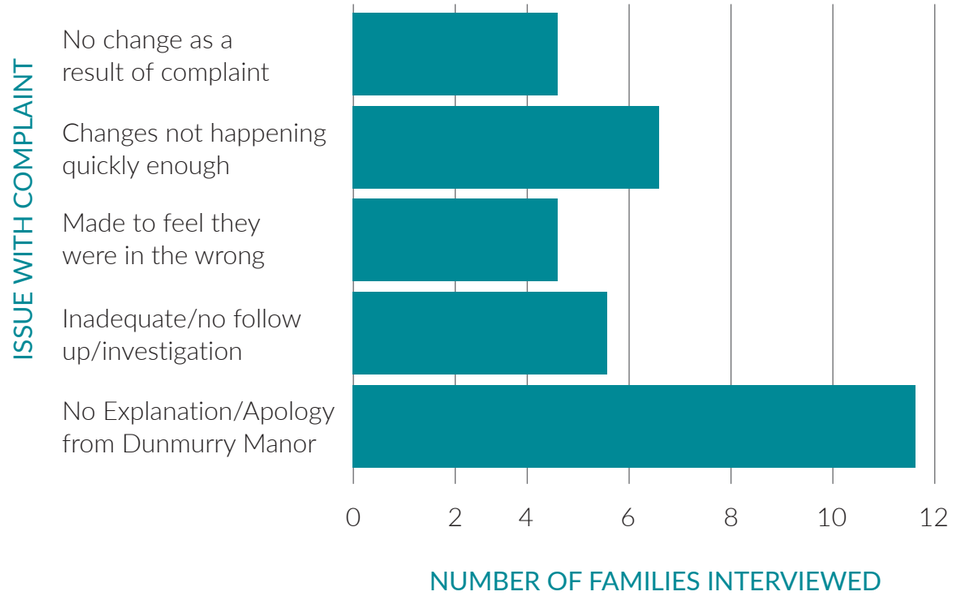


The process of making a complaint and any action eventually being taken was a fragmented process. The final outcome was often unsatisfactory to families. Below are quotes from families who saw no action or change as a result of making a complaint, and in some cases, reflect a view that there was 'no point' to making a complaint as it would not change anything in Dunmurry Manor:

- *"No one apologised for this. There was no apology or statement that the Home would do anything different, and no phone call from Dunmurry Manor to see how [resident] was."*
- *"Frustrating raising a concern because nothing changed…got fobbed off".*
- *"Complaints raised, while listened to, were rarely ever acted on."*
- *"They would always listen to our concerns but never did anything about them."*
- *"They didn't learn from complaints… we kept having to make the same complaints."*
- *"Complaints… you get to the stage there is no point making complaints. Dad said "get me out of this place."*

Given that some families of residents in care settings may feel reluctant to complain for fear of worsening care for their relative, the perception among some families that there was little point in complaining must be seen as a part of a double deterrent to families. Families clearly believed that the risk of making a complaint which may have an adverse effect on their relative was not balanced by a corresponding incentive, i.e. that the complaint would lead to improvements in care.

COPNI Interviews - Families Disatisfied with complaints to Dunmury Manor



Findings of the investigation in relation to Complaints and Communication

	Theme 8: Complaints and Communication (CC)
CC 1	Evidence of poor complaints handling
CC 2	Evidence of poor learning from complaints processes
CC 3	Evidence of poor communication with families and complainants
CC 4	Absence of feedback or follow-up reporting to families of residents following the raising of a complaint, concern or incident
CC 5	Evidence of confusion from families with regard to RQIA remit in complaints process.

Recommendations: Complaints and Communication

R49: Dunmurry Manor / Runwood must introduce an open and transparent complaints management system and welcome the early involvement of families and relatives in complaints resolution. Families should be well informed at all times of the next steps in the complaints process. 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.

R50: There must be improved communication between all bodies receiving complaints. Central collation would enable complaints to act as a better 'Early Warning System' about a failing home. A requirement for annual reporting of numbers and types of complaints, how they were dealt with and outcomes, would be a first step towards more open and transparent communication about complaints.

R51: Given the poor information sharing over the issues in Dunmurry Manor, there should be a central point of access where the RQIA can access all complaints made to a home. They must then use this access to track patterns and look at the detail of complaints that are indicative of serious concerns.

R52: Complaints statistics relating to care homes should be published annually and be made publicly available, subject to adherence to appropriate data protection protocols.

R53: A duty of Candour (see Section 9) must be introduced to provide a transparent and meaningful learning process from complaints.

R54: In the event of a complex and serious complaint not being resolved locally, an independent complaints process should be engaged that allows access to alternative dispute resolution providing appropriate support for whistleblowers and families.

4.9 Accountability and Governance

Conclusions: Accountability and Governance

The evidence gathered during the investigation supports the following conclusions in terms of the accountability and governance issues:

- It is clear that the responsibility for the delivery of care and support to older people in a home is diverse and complex and involves many different public bodies and organisations without adequate requirement to work cooperatively and collaboratively to do so.
- Evidence provided by Runwood Directors indicates a serious and significant disconnect between what was being reported to the Board and what was happening at a local level
- Evidence provided by RQIA witnesses, including Board Members that the serious failings identified at Dunmurry Manor were seen as "operational" and it was not considered necessary to escalate to the attention of the Board and Chairman
- Residents' families were unable to understand where accountability for failures in care and treatment resides in the system of care home provision
- A lack of ownership and follow up of information communicated to Dunmurry Manor, HSC Trust staff and the RQIA creating an environment where problems persisted for unacceptably long periods of time. Concerns were raised by relatives, staff to HSC Trust officials and by HSC Trust officials to the regulator for periods of months with no demonstrable change being affected in Dunmurry Manor
- The South Eastern HSC Trust, as host Trust, did not use the mechanisms available to them in their contract with Dunmurry Manor to bring about the change and improvements required in the home.

The independent sector provides 90% of all residential and nursing home care placements in Northern Ireland.[30] In 2017, there were 250 nursing homes and 194 residential care homes registered, with a number of larger companies owning multiple homes.[31] In the independent sector, it is important that individual homes and their parent companies be properly accountable for the standards of care provided and operate robust governance frameworks including the management of operational performance, communication, resourcing and budget.

Parent companies must strike the right balance in providing adequate autonomy for individual homes for the purposes of operational decision-making and company-wide oversight of compliance to legal and regulatory frameworks.

[30] https://www.health-ni.gov.uk/sites/default/files/publications/health/cc-adults-ni-15-16.pdf

[31] *https://www.rqia.org.uk/what-we-do/register/services-registered-with-rqia/*

Standards and Legislation

Standard 35 – Governance – 'Management systems are in place that assure the safe delivery of quality care within nursing homes.'

Resident A (see also safeguarding and human rights section)

Resident A (Res A) had experienced a number of falls, been hospitalised and was assessed after a period of rehabilitation, as requiring nursing care and placed in Dunmurry Manor.

Following a serious safeguarding incident, a safeguarding investigation was carried out on behalf of Res A and a meeting was due to take place between the family of Res A, the safeguarding team and the Runwood senior management.

The safeguarding investigation by the HSC Trust had completed approximately three months after the incident occurred. However, the Runwood report was still outstanding some nine months later. It became apparent during the first meeting between the HSC Trust staff member and the Runwood Senior management staff member that despite being copied into all the relevant information he had come to the meeting unprepared. A further meeting date was agreed for the family to attend. This date was cancelled at the last minute by regional management. It then took over four weeks for Runwood senior management to respond with a further date for this meeting. A HSC Trust member of staff described the senior management staff member's 'lack of commitment to meeting Res A's family… both derisory and contemptable.' (Sic.)

A HSC Trust staff member stated that documents which were requested from Runwood took approximately ten months to arrive with the HSC Trust and these documents were still incomplete.

With the exception of the Department of Health, all of the RAs are bodies that are at arms-length from either parent commercial companies or sponsoring Government Departments. Each has its own Executive team and Board. Evidence provided to the investigation highlights weaknesses in the oversight role of the RAs and each will be described below.

Throughout the Commissioner's investigation, families of residents have expressed the view that there is an absence of leadership across the system caring for their relatives. They have expressed an expectation that the system should be more easily navigated, that roles and responsibilities of different parts of the system should be more clearly explained and that it should be possible to easily understand who is accountable when things go wrong. Families who contributed evidence to the investigation described navigating the Health and Social Care system as time consuming, confusing, and stressful.

Department of Health

The Department of Health (the Department) in Northern Ireland is the Sponsoring Body for the RQIA. It is also the department with overall responsibility for the performance of the HSC Trusts (although each trust is individually constituted). There is no evidence that the seriousness or scope of problems at Dunmurry Manor was brought to the attention of the Department until November 2016, after Dunmurry Manor was deemed by RQIA to be in formal Failure to Comply with minimum standards.

At that time, the Department received an *"early alert."* Although it is not possible to know for certain what information was provided to Ministers (verbally), it is understood that a briefing was provided in writing.

The Department received the *"Cherrytree Report"*[32] and oversaw partial implementation of changes in response to recommendations made in the report. There is well-founded public expectation that the Department, as the top level of the hierarchy with responsibility for the provision of health and social care, is accountable for failures of the systems delivering such care. There do not appear to be adequate system processes or protocols to drive such ultimate accountability.

The Department appears to have only a peripheral involvement in this regard. The departmental officials who attended for interview during the investigation clearly emphasised that they had no involvement in the ongoing situation in Dunmurry Manor.

Dunmurry Manor / Runwood

Runwood Homes Limited is a private limited company, operating in England and Wales, and more recently expanding operations into Northern Ireland. The principal activity of the group is to provide high quality residential and day care services for older peoples' needs and those living with dementia or having a requirement for nursing care.[33] The group operates 10 residential and nursing homes in Northern Ireland ranging in size from 52-100 beds each. The published turnover of the group was £130,103,993 in the year ending September 2017, an increase of 10.8% from the previous year. The profit for the same period (before impairment) was £13,746,075. In the Directors' Report 2017, Runwood states that *"the Dementia Care Team, which was created three years ago, has continued to monitor, audit and report, as well as acting as advisers, in ensuring the highest quality of service is delivered in all homes when meeting best standards of care for those living with dementia."*

In August 2017, Runwood's Ashbrooke Care Home in Enniskillen was closed by RQIA because of *"serious risk to life"*. Thirty nine residents were removed from Ashbrooke Care Home and placed in alternative locations. Runwood lodged an appeal of the closure to the Care Tribunal in September 2017. In April 2018, the company withdrew its appeal.

The Northern Ireland homes are managed by a local regional director (the group's management structure and personnel have changed recently). The senior management of Runwood gave

[32] Full Title: The Independent Review of the Actions taken in relation to concerns raised about the care delivered at Cherry Tree House, Carrickfergus

[33] Runwood Homes Limited, Directors' Report and Consolidated Financial Statements for year ended 30/09/17 (the Directors' Report)

evidence that they had been informed by regional management that Dunmurry Manor was performing well overall. Yet senior management were in weekly contact with regional management in Northern Ireland and also recounted several visits to Dunmurry Manor since it opened. Evidence was provided by senior management that regional management had directed all correspondence to a Northern Ireland address, but it appears that this did not raise any concern with Runwood.

Accountability at all levels of independent providers of care and nursing is fundamental to ensuring public confidence. Clear audits and robust inspection protocols must be fully and consistently adhered to by all care home staff. From senior management down there must be genuine commitment to ensuring the accuracy of information provided to Board level and action taken if and when such information is found to be incomplete.

There was a lack of evidence of Board level oversight provided to the Commissioner's investigation. Board minutes should have reflected the ongoing difficulties reported by staff at operational levels in Dunmurry Manor prior to the formal enforcement action taken in November 2016. Further concerns surrounding the Failure to Comply Notices being served upon Dunmurry Manor and the actions to be taken do not appear to have been reported to or discussed by the Board. A clear and transparent process for addressing significant deficits in care and treatment, in managing improvement and associated risk should be in place at Board level. Evidence of this was not provided to the Commissioner.

Interviews with Runwood Directors highlighted an overreliance on the assurances of one regional manager. Where a parent company is not locally based there should be additional checks and balances in place to ensure consistency and quality of care provided.

The evidence provided to the investigation highlights a consistent problem with the content and effectiveness of audits, for example of care records or medicines, with these being mentioned frequently in the RQIA's inspection reports since April 2015. At a Serious Concerns Meeting with members of the RQIA and the South Eastern HSC Trust present, concerns were expressed about the quality of governance arrangements in Dunmurry Manor and it was stated that *"there was no evidence that there were effective systems in place for reviewing, at appropriate intervals, the quality of nursing and other services provided by the home."*

The assurances provided to the Runwood officials, that all operational matters were in hand, directly contradicts the evidence given to the investigation from other levels of management and staff. Evidence submitted to the Commissioner reflected a degree of frustration from local managers about the support given by Runwood HQ to the management of Dunmurry Manor. A former manager who had just taken up post described the action plan developed in response to requirements from inspections as not addressing the pertinent issues.

A different former manager described being provided with an action plan and told by Runwood management *'it is over to you'* – with the result that they said they felt *'unsupported'*. A senior HSC Trust representative commented that *"Runwood is a cause for concern – over the last 5-6 years. When you get an organisation like Runwood which is purely business orientated and the managers are not being given the required level of support and resources."* Evidence suggests that the approach taken by the HSC Trusts was to report concerns to the RQIA and to place experienced staff in the home for a short period in 2016-17 to provide hands-on support. The RQIA continued to undertake a type of management by frequent inspection. This proved to be unsustainable for the South Eastern HSC Trust which then removed the additional support prior to commencement of the Commissioner's investigation.

A former Runwood staff member said head office were *"continually trying to push to fill beds; they would tell you this is a business, we are running at a loss; it wasn't making money."* One HSC Trust staff member said one of the former managers was being asked to run Dunmurry Manor by head office with a lower level of staff than they really needed. One member of senior management would have *"promised the sun, moon and stars but saw no evidence of him actually being able to turn anything around."*

Those staff members making such comments did not provide evidence of actions taken to address their concerns, by them or others. Nor did any RA take up the opportunity to cross-examine this evidence or produce evidence or witnesses to refute it.

RQIA

The statutory role and responsibility of the RQIA has been addressed in detail in Chapter five. This chapter is concerned with the role RQIA has or could have in protecting the interests of residents and their families.

There is a clear disconnection between the public expectation of the role of the regulator in dealing with care home complaints, safeguarding concerns and inspection protocol and the technical oversight of the Regulations governing nursing and residential homes. Whilst it is important that each public body involved in the commissioning, provision and regulation of care does not duplicate another's role, the result of the current architecture, roles and responsibilities is a complex system where the rights and needs of the individual older person are not given sufficient priority.

The officials of RQIA interviewed during the investigation were clear in terms of the limits of their role not extending to monitoring the performance of Dunmurry Manor and the management of complaints by families. However, their strict adherence to their current approach to inspection proved unhelpful in recognising, reporting and addressing the evident failures of care and treatment in the home.

Despite not being aware of all that was happening within Dunmurry Manor, the RQIA did have a volume of knowledge through individual inspectors, incident reports and material logged on their internal systems, that indicated substantial issues in Dunmurry Manor. Despite individual pockets of knowledge within the organisation, the RQIA as a whole was not aware of the seriousness and scope of concerns about residents in Dunmurry Manor. RQIA inspectors and managers did not deem the knowledge of problems at Dunmurry Manor to require escalation to the most senior Executive or Board level.

Although at each Board meeting a senior official reported on enforcement activity and other compliance issues, Dunmurry Manor received limited mention. The Commissioner's investigation is recorded as being mentioned once in the Board Minutes and no detail of the discussion is recorded. When

interviewed a number of Board members, including the current Chair confirmed that their knowledge about the failures of care and treatment was restricted to a briefing received by senior RQIA officials prior to interview.

At interview and in documentary evidence, a previous Chair of RQIA was critical of the pace and scale of change in implementing the recommendations of the Culture of Care and the Cherrytree Report. Implementation of such changes arising from previous advice would likely have contributed to better handling of the issues at Dunmurry Manor. The evidence of the former Chair was provided to the investigation in 2017, nearly three years after the recommendations of these reports had been published.

All public bodies involved in the provision of care must display clear ownership and accountability. It should be clear which organisation is responsible and at what point action should be taken. The Commissioner is concerned that the Board of the RQIA does not appear to take a more active involvement in the strategic oversight of failing care homes.

HSC Trust Responsibility

Four of Northern Ireland's HSC Trusts collectively placed residents in the home as well as providing training on a number of occasions, on a range of older peoples' care issues. Their placement of residents in the home triggered a statutory requirement on these HSC Trusts to *"put and keep in place arrangements for the purpose of monitoring and improving the quality,"* of the service provided.[34] In parallel to these arrangements runs the Trust's duty in terms of receiving and investigating complaints. The HSC Trusts have a role that goes beyond placement and includes responsibilities that last through a resident's tenure in a home. Each HSC Trust retains a duty of care for residents placed, by it, in homes operated by independent providers. Through the processes of needs assessment, monitoring and review of care, HSC Trusts must ensure that each resident receives care and treatment compliant with the Minimum Nursing Standards.

It is clear from evidence provided and interviews with officials from the HSC Trusts that concerns were raised by staff with responsibility for residents in Dunmurry Manor and meetings were held between the four HSC Trusts affected. Minutes provided show concerns raised in respect of all aspects of the care provided as well as the role of the RQIA.

What is not clear is the reason why the level and frequency of concerns were not escalated to the Chief Executive of each HSC Trust and particularly the host HSC Trust at the earliest point. Staff at middle-management grades and below commented on their frustration at not being updated once concerns had been raised to senior managers.

A senior official from the South Eastern HSC Trust commented on the limited *"levers of control"* available to be used to address the ongoing situation in Dunmurry Manor. The contractual basis of the relationship in place between the South Eastern HSC Trust and Runwood is governed by the Regional Contract (the *"Regional Contract"*) in place for Northern Ireland. The poor / unsatisfactory performance was not challenged under the terms of the Regional Contract. The Regional Contract allows for the withholding of up to 20% of the monthly sums payable under the contract in the event of a material breach which has not been remedied. The South Eastern HSC Trust did not exercise these contractual clauses against Runwood. The evidence supports the conclusion that the HSC Trusts did not use the mechanisms available to them in the Regional Contract to ensure providers maintain levels of service delivery to the required standards.

Duty of Candour

Throughout this investigation, the Commissioner has been frustrated by the lack of certainty that full disclosure of evidence has been made by the RAs as well as the delay in production of information and documentation by a number of them. This was further exacerbated by the slow response and lack of availability of some witnesses for interviews. Some HSC Trust staff and Dunmurry Manor staff and former staff appeared reticent to openly challenge the status quo. Many families and relatives spoke of their frustration at not being able to speak openly to staff and management and that they became seen as part of the problem when they raised concerns or complaints. It is concerning that, despite the legislative protections for whistleblowers, witnesses expressed a chill factor in making adverse comment or reporting concerns.

A commitment to improve the care, treatment and protection of residents must be more than words. This is particularly important given the findings from the recent Inquiry into Hyponatraemia – related deaths[35] and the previous Mid Staffordshire NHS Foundation Trust Public Inquiry[36]. Both of these Inquiries highlighted a disturbing lack of honesty and openness with families and the Inquiry reports recommended that a statutory duty of candour be imposed where death or serious injury had occurred. The recommendation[37] from the Inquiry into Hyponatraemia – related deaths is for the establishment of a duty of candour in Northern Ireland which would attach to both individuals and organisations in the event of death or serious harm to an individual in a health care setting. The Commissioner also makes this recommendation.

[34] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

[35] The Inquiry into Hyponatraemia-related Deaths: Report, January 2018.

[36] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013.

[37] The Inquiry into Hyponatraemia-related Deaths, Recommendations 1-8, pp.84-86.

Findings of the investigation in relation to Accountability and Governance

	Theme 9: Accountability and Governance (AG)
AG1	Lack of ownership and accountability for progressing improvement action plans following inspections
AG 2	Evidence of persistent delays from Runwood Homes Ltd in making themselves available for important review meetings on complaints and safeguarding issues
AG 3	Evidence of the Relevant Authorities' lack of confidence and frustration with Runwood senior management's ability to commit to the level of improvement required
AG 4	Evidence of a lack of local decision-making authority and the fact that head office held budget sign-off, leading to delays with ordering and availability of necessary stock and supplies

Recommendations: Accountability and Governance

R55: The sharing and analysis of communication regarding concerns about low standards of care must be improved within and between the HSC Trusts, the RQIA, including its Board and the Department of Health to enable a more efficient and effective information flow, action and follow-up in all matters pertaining to failures of care.

R56: Those who commission care should assure themselves that they contract with organisations which have strong governance and accountability frameworks in place. Record keeping should be subject to rigorous and regular audit.

R57: An individual Duty of Candour should be introduced in Northern Ireland for all personnel and organisations working across and in the system which governs and delivers care to older people to encourage openness and transparency.

R58: The Regional Contract should be reviewed and training provided in relation to its content and 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.

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.

5.0 Investigation Conclusions and Summary of Recommendations

Structure and content of the Investigation Report

As a result of the evidence gathered in this investigation, the Commissioner is making **59 recommendations** across 9 aspects of health and social care provided at Dunmurry Manor Care Home. The recommendations are re-stated at the end of this report.

General Observations

This investigation has highlighted the significant failures of RAs to take action in order to address issues quickly and effectively and to ensure improvements. The HSC system must accept that processes and procedures currently in use were ineffective in this case, and must learn from the experience of the families of residents in Dunmurry Manor.

There is a public expectation, particularly amongst family members of residents of Dunmurry Manor that those responsible for poor care and treatment will be held to account. The Commissioner's powers do not extend to penalties and the investigation cannot determine either civil or criminal liability.

However, the Commissioner expects the leadership of the HSC system to take immediate appropriate action to hold to account any individuals or bodies failing in their duty to care for and safeguard the health and wellbeing of the residents of Dunmurry Manor. Where findings, conclusions and recommendations are made, it is expected that lessons will be learned and changes will be made by the RAs. The Commissioner will monitor the RAs' actions to address the recommendations made within the report and will draw attention to any failure to implement changes that will prevent any recurrence of these events in Dunmurry Manor.

Repeating the mistakes of the past

Providing care for older people made vulnerable by frailty and dementia is among one of the most rewarding but intensive areas of employment and service provision. Sporadic adverse incidents or unusual events in care settings are to be expected and indeed, systems for reporting and monitoring such matters already exist.

Unfortunately, it is clear from the evidence provided to this investigation that shortcomings in the care and treatment of residents in Dunmurry Manor were common place. The *Cherrytree* Report in 2014 highlighted similar shortcomings in care in another home over an 8-year period and the experts made recommendations for change to the health system. Shortly thereafter the inaugural Commissioner published advice to government, *Changing the Culture of Care* (November 2014) which supported the recommendations of the Cherrytree Report and went further in making more recommendations for whole-system change.

Since 2014 the Commissioner has repeatedly sought assurances from the Department that action is being taken across and within the HSC system to implement the recommendations, or to explain why actions cannot be taken. The responses to the recommendations have been piecemeal, slow in pace and inadequate in scope to address the recommendations. Until the leadership of Health and Social Care in Northern Ireland takes responsibility for improvements in care and acts swiftly to address the failings demonstrated in Dunmurry Manor, the public can have no confidence that the circumstances at Dunmurry Manor are totally resolved.

Warning Signs

Over the sixteen months that the investigation has taken place, the complexity and structure of the "system" which provides, funds, regulates and monitors the provision of residential and nursing care in Northern Ireland has been subject to significant review and a series of recommendations for change have been made.

Currently, each RA has established roles and responsibilities in relation to the placement, monitoring and review of residents placed in care settings. These include:

- Assessing the care needs of older people seeking residential or nursing care
- Arranging the placement of residents
- Funding the care of some residents (on a means-tested basis)
- Regular review of the suitability of the placement of each resident
- Regulation and inspection of care settings
- Investigation of safeguarding incidents
- Management of complaints
- Notification of events and incidents

This investigation reveals that there was inadequate cooperation between the Trusts and the RQIA. There were clear opportunities to share information that were missed, and opportunities to act on information that was received, were not taken.

Drawing together evidence from all of the RAs (where provided) and setting it alongside witness evidence demonstrated clearly that, although multiple organisations were involved at different points in the first two and a half years of Dunmurry Manor operating, none of the individual authorities were aware of the full scale of the issues being experienced by residents in the home. A chronology timeline is attached at Appendix 4 (end of the report).

- There was a wide variety of issues within Dunmurry Manor leading to poor care and treatment of residents.
- Serious issues and incidents were occurring in Dunmurry Manor from an early stage.
- Issues continued throughout the timespan examined by this investigation, worsening in volume at points, and continuing for a significant period after Dunmurry Manor had been served Failure To Comply Notices.

More effective action at an early stage could have prevented the worst of the problems experienced by some residents. However the different parts of the system were not able to work collectively to bring this about, despite each RA having awareness of some of these problems. Even in cases where information had been shared, such as from the Northern HSC Trust March 2017 monitoring visit, there did not appear to be active follow up by the RQIA on an inspection just 6 days later. The table which commences on page 74 of this report shows the RQIA Inspection process did not uncover the true extent of the problems within Dunmurry Manor.

"Red Flags"

Many families made constructive, specific complaints to Dunmurry Manor, Runwood, the HSC Trusts and RQIA. Families expressed frustration that they could not get these matters resolved. As well as individual families having their complaints addressed, if the RAs had been monitoring complaints to identify thematic problems, the seriousness of the circumstances at Dunmurry Manor may have been more swiftly identified and action taken.

The system did not take decisive action when Dunmurry Manor was demonstrated to be failing, especially after receiving three FTC notices as part of the enforcement action taken in October 2016. The enforcement action conditions, including closing the home to new admissions for a period up to ninety days, were not lifted for nine months.

Often Dunmurry Manor was able to appear to meet minimum standards during periods where there is evidence from those interviewed of significant problems in their relatives' care and treatment. This report advocates for the inspection system to become more attuned to the signs that a home is in trouble, and support this with an enforcement system that adheres to tighter timeframes and allied to changes in contracts and the ability of the commissioning HSC Trust to exercise penalties. These steps would equip the system to ensure that providers have more powerful incentives to get things right at the earliest stage possible and to maintain appropriate levels of care.

Many families of residents told the investigation that they wish they had understood better how to choose the right home for their relative. They said that, beyond the glossy brochures, produced by individual homes, it is not possible to know a well performing home from a poor one. Families complained that they were unaware of the RQIA and that when they were directed to it, they found the inspection reports difficult to access and hard to understand.

The HSC system must use the negative experiences of families to improve the accessibility of information and help families to make an informed decision about which care home to choose for their loved one. The Commissioner recommends the introduction of a rating system for care homes and increased accessibility to detailed information about the performance of care homes against the standards. The RAs should become more proactive at seeking the involvement of relatives in the assessment of the quality of care being delivered.

Lessons to be learned

Dunmurry Manor

The investigation found that Dunmurry Manor had problems delivering acceptable standards of care from the very early weeks and months of the home opening. A common theme from interviews was staff issues. It should have been clear to local management that staff were struggling to deliver the fundamentals of care which was further compounded by the high levels of agency staff who were unfamiliar with the residents. Many staff interviewed felt Dunmurry Manor was providing inadequate levels of training, mentoring and induction, making it difficult for new staff to provide an appropriate level of personalised care.

What several interviewees described as the 'chaos' within the home caused low morale and some staff to leave with some agency staff expressing their concerns after only one shift. Dunmurry Manor could not retain experienced staff, and as a result had to constantly hire new staff who did not have long-standing knowledge of the home and residents, further hampering efforts to provide a high standard of care.

The HSC system should have done more to recognise the cycle of staff attrition and require Runwood Homes to address the matter.

Dunmurry Manor/Runwood Homes ability to take decisive action to address its own shortcomings was compromised by a culture of blame from some members of senior management. New managers gave evidence that they received minimal advice and support from regional management, whilst Runwood Homes HQ appear to have accepted assurances without question from Northern Ireland management that the home was performing well. The Commissioner believes this contributed towards the high turnover of managers, with ten managers having been employed (nine of whom left) since it opened. The failure to secure long tenure of a manager in the home caused uncertainty among staff, and disrupted focus on addressing the issues in Dunmurry Manor. Runwood HQ management were slow to react to problems that were drawn to their attention by HSC Trusts and RQIA.

Dunmurry Manor had unique insight into the problems and the serious safeguarding incidents. Instead of addressing the problems, members of senior management portrayed that the home was improving and delivering high levels of care. The significant problems Dunmurry Manor had around progressing complaints, record keeping, and obtaining input from families meant Dunmurry Manor was losing opportunities to gain information that could have been used to flag up problems earlier and make lasting improvement.

A priority for Runwood / Dunmurry Manor is the need to end the cycle of high staff and managerial turnover, as this created the context for many of the problems to develop. Senior management need to give managers the support to address issues arising.

Better staffing levels and retention of existing staff, would improve the

provision of high quality, personalised care within Dunmurry Manor, while giving staff more time to ensure the home has acceptable standards of environmental cleanliness.

The evidence gathered indicates that investigations into serious incidents at the home were hampered by incomplete documentation. Ensuring records are maintained thoroughly and correctly is vital, as gaps in records have many consequences for the provision of care and medicines and for the progression of investigations when incidents happen and for proper audit purposes.

Runwood Homes should reconsider the budgetary and administrative practices that led to departments within Dunmurry Manor not being able to order important equipment, and staff having to occasionally buy this equipment themselves.

RQIA

The investigation clearly uncovered the differences of professional opinions about the lived experience at Dunmurry Manor. Despite many complaints from families of residents and despite HSC Trusts voicing significant concerns about the performance of the home, RQIA inspections found only a proportion of the problems uncovered by this investigation.

What was noteworthy in the evidence gathering was that several RQIA witnesses who gave evidence to the investigation said that "*Dunmurry Manor is not the worst*". The Commissioner is concerned that there is a degree of de-sensitivity to what are acceptable norms in a care home. It is clear that RQIA inspectors did not see the extent of the problems at Dunmurry Manor and that if they had seen the totality of the evidence provided to the investigation it is hoped that the action taken would have been different.

The public relies on the RQIA for assurances that the services caring for and protecting their relatives are safe, effective, compassionate and well led. Even allowing for the information that was not disclosed to or sought by the RQIA, it is clear that it did not identify the scale of the poor performance of Dunmurry Manor quickly or effectively.

Overcoming structural barriers

People who do not work in the Health and Social Care Service often expressed that they find the system confusing and complex. Families of residents gave evidence that this complexity is unhelpful when trying to find someone to provide information or deal with a complaint. It makes no sense to the public that the regulator will not listen to their complaints and try to address them. The formal complaints processes managed by Dunmurry Manor/Runwood and the HSC Trusts were not the subject of any positive comments during the investigation.

Employees of the HSC system gave evidence in their interviews that they too experienced frustration in trying to work with processes and protocols that intended to bring together various individuals or services to work together towards a common goal. The most significant of these was the professional relationship between the Trusts and RQIA. The investigation team asked officials why it was difficult to get information to pass easily between services, and it is clear that there is limited resource or imperative to improve the communication, align service delivery and oblige follow-up between different parts of the system.

The RQIA is the regulator of all care settings, not just of the independent providers, but also of the HSC Trusts themselves and as such carries a significant amount of power in the system. As one Trust official commented *"you don't argue with the referee"*.

HSC Trust officials also expressed difficulty in requiring independent providers to make improvements given the contractual relationship between the HSC Trusts and the providers. HSC Trusts seem apparently unable to influence the providers to make significant improvements to services without drawing in the RQIA to "enforce" change. In the case of Dunmurry Manor it is clear that the South Eastern HSC Trust tried to do this, but that inspection findings did not accord with what HSC Trust staff and allied health professionals knew was happening on the ground.

Solving these difficult challenges in the management of poor performance by independent providers will not be possible if the Department takes the findings of this investigation and asks each part of the system to address the problems identified in their part of the service. That has not worked in the past. The changes that are required to be made will have to be worked through the whole system of care assessment, placement, monitoring, funding and regulation.

Management of complaints to drive service delivery

The proper management of complaints is a key driver of improving services. Each complaint must be considered on its own merit and should be resolved quickly and as effectively as possible. But where there is a collection of complaints about a particular service, this information is vital to those delivering services of thematic or systemic problems.

Although there was information available regarding Dunmurry Manor, insufficient and slow processing of it enabled problems at the home to worsen to the point that the frustration of families of residents became unmanageable by the HSC Trusts. Had there been a process for collecting and identifying themes arising from complaints, it would have become clear that Dunmurry Manor was a home that was struggling to retain staff and managers and that similar complaints (as outlined in the Chapters regarding Care and Safeguarding) were consistently and legitimately being made.

There is no evidence that this type of collation and analysis was undertaken by the HSC Trusts and the RQIA.

Additionally, the absence of intelligence about the state of the services left senior officials uninformed about matters that were deemed to be "operational". No doubt one or two of the incidents occurring at Dunmurry Manor could be deemed operational but given the excessive number of adverse events outlined in the evidence provided to the investigation, someone at a senior level should have been better informed about the challenges faced by residents at Dunmurry Manor.

Senior officials of the HSC Trusts gave evidence that they took the assurances given to them by more junior staff, mostly without question. Few of the officials at the most senior levels of the HSC Trusts were informed about concerns, challenges and difficulties in dealing with poor care and safeguarding at Dunmurry Manor until the FTCs were in place and shortly before the Commissioner's investigation commenced.

Other large institutions recognise that a large accumulation of smaller problems inevitably create a significant risk of harm. There was no valid reason given for failing to escalate the concerns relating to Dunmurry Manor except that no individual or authority was aware of the totality of evidence that circumstances at the home were unacceptable. Consideration must be given by the health and social care authorities on the escalation of concerns from the "operational" to the corporate level so that the influence of more senior officials can be brought to bear on matters that are so serious and long-standing as they were in Dunmurry Manor.

6.0 Summary of Recommendations

	Safeguarding And Human Rights
R1	An Adult Safeguarding Bill for Northern Ireland should be introduced without delay. Older People in Northern Ireland must enjoy the same rights and protections as their counterparts in other parts of the United Kingdom.
R2	The Safeguarding Bill should clearly define the duties and powers on all statutory, community, voluntary and independent sector representatives working with older people. In addition under the proposed Adult Safeguarding Bill there should be a clear duty to report to the HSC Trust when there is reasonable cause to suspect that there is an adult in need of protection. The HSC Trust should then have a statutory duty to make enquiries.
R3	All staff in care settings, commissioners of care, social care workers, and regulators must receive training on the implications of human rights for their work.
R4	Practitioners must be trained to report concerns about care and treatment in a human rights context.
R5	Policies and procedures relating to the care of older people should identify how they meet the duty to be compatible with the European Convention on Human Rights.
R6	The registration and inspection process must ensure that care providers comply with the legal obligations imposed on them in terms of human rights.
R7	The Department or RQIA should produce comprehensive guidance on the potential use of covert and overt CCTV in care homes compliant with human rights and data protection law.

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

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

	Environment and Environmental Cleanliness
R22	It must be a pre-registration requirement for RQIA and a pre-contract requirement for HSC Trusts that all new Care Homes specialising in dementia care comply with Dementia Friendly building standards [and that buildings already in place are subject to retrospective "reasonable adjustment" standards].[40] This must form part of periodic inspections to ensure suitability is maintained.
R23	Premises must be one of the areas that RQIA Inspectors routinely inspect as an integral part of an integrated inspection with a focus on the condition of residents' rooms.
R24	Runwood must devolve goods and services budgets to a local level for staff to manage.
R25	The RQIA must review how effective inspections are for periodically covering all of the Regional Healthcare Hygiene and Cleanliness Standards and exposing gaps that a home may have in relation to these.
R26	Consideration should also be given to expanding these Standards in line with the NHS 'National Specifications for Cleanliness', which emphasise additional issues like the Cleaning Plan of the Home and a specified standard of cleanliness for different parts of the home/different types of equipment.
R27	The programme of unannounced 'Dignity and Respect Spot Checks' should also include assessment of the suitability and state of the environment. In Dunmurry Manor the breaches of key environmental indicators raise the question of whether residents were being treated with appropriate dignity and respect and whether this should have triggered warning signs about Dunmurry Manor at an earlier stage.
R28	Integrated inspections which cover all of the lived experience of residents should be introduced by the RQIA as soon as possible.

[40] Dementia Friendly Building Standards include the dementia - Friendly Health and Social Care Environments, Design for Dementia Audit Tool, the Environmental Audit Tool and the Enhancing the Healing Environment Environmental Assessment Tool. They include requirements on construction elements of a building, elements that can improve the built environment (such as artwork and signage), technical aspects (like acoustics, colour or lighting), and general design principles, such as multisensory environments, avoiding overlong corridors and areas of crowding, and uses of textures and colours

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

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

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

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

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

7.0 Next Steps

Schedule 2 (3) and (4) of the COPNI Act 2011 outline how the Commissioner must report on an investigation as well as the requirements for *"Further action following report on the investigation."*

The recommendations made by this report are supported by comprehensive evidence and the Commissioner believes, if implemented, they will improve standards. The recommendations clearly describe the action that needs to be taken and the desired outcomes. There would be a continuing negative impact upon older people if the recommendations are not implemented.

On receipt of the recommendations of this report, s.15 (1) 6 of the 2011 Act states that the RAs should consider the Recommendations pertaining to them, and determine what action they should take in response.

Within three months of the issue of this report, the Commissioner will require the RAs to provide documents that set out either:

- How the RA has complied or proposes to comply with the Recommendations pertaining to them
- Why they have not complied with these Recommendations
- Why they do not intend to comply with these Recommendations

The Commissioner will consider the responses issued, and will issue a statement outlining the overall assessment as to whether the actions detailed in the responses will deliver the outcomes expected. The Commissioner may also need to issue a further notice should there be any failure to respond from RAs. The COPNI Act 2011 affords one further month for response from the RA if the Commissioner considers that the initial response and documentation received is inadequate.[41]

The recommendations are varied and some will require time and effort that extends past the period described above. The Commissioner will assess options and timelines for progress and believes that ongoing communication with RAs about the approaches they are taking to implement the recommendations is essential.

The Commissioner intends to hold meetings with the RAs with regard to implementation of the recommendations. This will provide an opportunity for the RAs to describe what they are doing and by when. One year after the publication of this report, the Commissioner will publish a report outlining the progress made by the different RAs in implementing the recommendations, and what implications this has for the sector.

The Commissioner will maintain a Register of Recommendations in line with Schedule 2 (4)(5) of the 2011 Act. This Register will detail the recommendations, the action taken so far, and the results.

[41] Given that this report is published in June, the Commissioner considers it reasonable to discount the 2 week July holiday period from this timeframe.

Expected Impact of Recommendations

Recommendation Theme	Expected Outcome	Impact of Recommendation Implemented	Relevant Authority
1. Safeguarding and Human Rights Recommendations (Section 4.1 of report)	Homes and Relevant Authorities will have more clarity about what incidents should be classified, reported and investigated as safeguarding incidents. The duties and powers of all statutory, community and voluntary sector representatives involved in the process are clearly defined. All staff in care settings, commissioning and in the inspection process have an increased ability to apply knowledge of Human Rights law to their work. Human Rights considerations are embedded in the registration and inspection process from the earliest stages, enabling residents' Human Rights to be more effectively protected. Additional clarity about the circumstances about when CCTV can be used in a Care Home.	Older people in Northern Ireland would enjoy the same rights and protections as counterparts in Great Britain in relation to Safeguarding law. More certainty in the system with standard requirements on Homes to report to Trusts when there is reasonable cause to suspect there is an adult in need of protection. Human Rights will be embedded in the training for staff in the Home. The work of inspectors both before and after the registration of a Home focuses on Human Rights considerations. Consistent approach to the use of CCTV in nursing homes	Department of Health, RQIA, Runwood Homes
2. Care and Treatment Recommendations (4.2)	Families are better informed of what Care Homes are doing to protect their relatives. They will also have more information on what to do and who to speak to if there are incidences of poor care. Residents and their families are able to make well-informed choices about where their relative should be placed, which are better supported by care professionals. Care becomes more personalised as families are more closely involved in the development of Care Plans. Standards of Care are more closely monitored by Trusts, with this monitoring better informed by the opinions of family.	Improved access to information and guidance for families who have to choose a Care Home for their relative. Families share knowledge about what is being done to care for their relative.	RQIA, HSCT's, Runwood Homes

Recommendation Theme	Expected Outcome	Impact of Recommendation Implemented	Relevant Authority
3. Medicines Management Recommendations (4.3)	There are reduced levels of medication errors in Care Homes. Families are more involved in the provision of medicine to their relatives, and more aware of what medications are being given. Better training of staff and better recording of what medicines are being administered to residents' means that staff will be better equipped to identify problems with medicines management at an early stage. Ongoing and reported medication errors, not just problems uncovered at the time of an inspection, will be used to inform the overall picture of how a Home is doing.	Reduction in major medicines errors leading to better managements of behaviours that challenge, and treatment of co-morbidities. Increased likelihood of trends of medicine mismanagement being noticed and addressed.	Runwood Homes, RQIA
4. Environment and Environmental Cleanliness Recommendations (4.4)	Newly built care homes will be of suitable design for those with dementia. Estates and Design will become a larger part of the present process of Inspections. Investigating the state of Residents' rooms, an area where there were many problems at Dunmurry Manor, will become a regular part of inspections. Standards of cleanliness will be more rigorous. Breaches of key environmental indicators will trigger investigation from an earlier stage. Active consideration of Dignity and Respect will form a key part of inspections.	Residents will benefit from improved living conditions arising from improved design and layout. Aspects of design and estates will only be part of inspections when there are major problems. Significant lapses in what should be essential levels of good hygiene, especially in residents' own rooms will be less likely.	Department of Health, RQIA, Dunmurry Manor, Runwood Homes,

Recommendation Theme	Expected Outcome	Impact of Recommendation Implemented	Relevant Authority
5. Regulation and Inspection Recommendations (4.5)	A Performance Rating system will make it clearer to the public how Homes are performing, and provide a further incentive for Homes to improve. A system of Financial Penalties will act as a deterrent to providing poor care, and demonstrate that such provision will be penalised meaningfully. Families will have more clarity about the role of the RQIA and have the option of making complaints to them, resolving many of the issues raised in interviews.	It will be much simpler and easier for families to judge the performance of different Care Homes and make comparisons of multiple homes in locations. This will provide a further mechanism with which to enforce improvements by providers. Complaints information will be used to enable the monitoring of trends of problems, and earlier targeted action to address them.	RQIA, Department of Health
6. Staff Recommendations (4.6)	Homes will have sufficient levels of staff for residents with high needs. Homes have more clarity on the staffing levels they need. Levels of staff retention will be a standard trigger for further investigation. The levels of Agency staff will also be a flag to Inspectors. In Dunmurry Manor problems with staffing caused many impediments to delivering high quality care, so this being a warning sign will mean a failing Home is potentially flagged up for detailed investigation earlier. Staff are more supported and encouraged to give information to inspectors.	Adequate ratio of staff with the right skill sets to meet the assessed needs of the residents. Better retention of permanent staff leading to reduced reliance on agency nurses. Homes will have a clear incentive to ensure the correct staff levels are in place and reduce staff turnover.	RQIA, Department of Health, Royal College of Nursing, Chief Nursing Officer,
7. Management and Leadership Recommendations (4.7)	Frequent changes of Manager should act as a trigger for the inspection of a home. Incidents of inappropriate behaviour by managers more likely to be investigated which will encourage a more open culture. Concerns that are being stymied by the Home could be easily escalated to an external body giving staff more options to have their concerns addressed and resolved.	More stable retention of registered managers providing continuity of leadership.	RQIA, HSCT's,

Recommendation Theme	Expected Outcome	Impact of Recommendation Implemented	Relevant Authority
8. Complaints and Communication Recommendations (4.8)	Complaints will be centrally collated, enabling all relevant authorities to gain a clearer picture of what really is happening in a Home. Families and other interested parties (including those wishing to place a resident) will be able to more readily access information on the level of complaints made about a home. There will be a more open culture that prioritises improvement, with the introduction of measures like the duty of candour. Feedback does not have to be in the form of a complaint to trigger an investigation. The views of families who may be reluctant to make a complaint will still be reviewed in a similar way to a formal complaint and appropriate action taken.	Complaints and resolution will be shared across authorities with responsibility for the care and treatment of residents. Families supported in seeking to progress a complaint. Increase transparency with the public on the management and resolution of complaints. Increased imperative on providers to address complaints early and more effectively. A lack of feedback on complaints will be used as intelligence for those monitoring or regulating nursing homes, aiding the early identification and resolution of concerns.	Dunmurry Manor, Runwood Homes, Department of Health, RQIA,
9. Accountability and Governance Recommendations (4.9)	When there are failures in care, each of the Relevant Authorities will be clear about their role, and will have access to the information they need. Appropriate and speedy escalation of concerns will elicit action from senior officials and drive requirement to improve performance in the independent sector. The culture of the system is more open to highlighting instances of poor care at an earlier stage than was seen in this investigation, and to innovating.	Clear, consistent and speedy reaction from the relevant authorities will drive improvement in the care and treatment of residents. A culture of poor performance and frequent failure to comply with minimum standards will no longer be tolerated or permitted to continue for extensive periods of time.	RQIA, Department of Health, HSCT's.

Annex I

Legal Powers

The Commissioner for Older People Northern Ireland was established in 2011 under the Commissioner for Older People (Northern Ireland) Act 2011 and was granted a range of powers and duties to promote and safeguard the rights and interests of older people.

Since being established the Commissioner has published a range of statutory advice to government seeking to improve outcomes for older people in health and social care, crime detection and prosecution, employment, safeguarding older people from abuse and changing the culture of care.

The legal casework undertaken by the Commissioner has relied largely on the less formal powers of advocacy and alternative dispute resolution, although the Commissioner has powers to litigate on behalf of an older person or to provide resources to support an older person to litigate.

The investigation into Dunmurry Manor Care Home (Dunmurry Manor) was commenced using the non-formal investigatory powers outlined in Schedule 2 of the COPNI Act 2011 which provides that it must be conducted in private.

Until February 2017, the Commissioner had not exercised the Schedule 2 powers of the COPNI Act 2011, which allow, at the Commissioner's discretion, for a statutory investigation into specific matters affecting older people. The Commissioner's Investigatory powers fall into two different categories;

- Formal investigatory powers
- Non-formal investigatory powers

The investigation into Dunmurry Manor was commenced using the non-formal investigatory powers outlined in Schedule 2 of the COPNI Act 2011.

Background and Chronology of Events

Dunmurry Manor Care Home (Dunmurry Manor) is a 76-bed residential and nursing home located at Seymour Hill, Dunmurry, Belfast, owned and operated by Runwood Homes. It is located within the catchment area of the South Eastern Health and Social Care Trust (South Eastern HSC Trust). However, in total, four of the five Health and Social Care Trusts in Northern Ireland have placed older people in Dunmurry Manor.

Dunmurry Manor is registered as a home that specialises in dementia care. The newly built home opened in 2014 providing modern resident accommodation. In November 2016, the Regulation and Quality and Improvement Authority (RQIA) issued three Notices of Failure to Comply with the Regulations for Nursing Care, signaling that the home was not meeting the minimum nursing home care standards.[42]

In December 2016, two families requested assistance from the Commissioner's legal team in relation to concerns and complaints they had made about their relatives' treatment in Dunmurry Manor. Both cases involved alleged failures of care and treatment of the older person as well as poor management action and reaction when complaints were made.

In the same month the Commissioner was contacted by two former members of nursing and care staff in Dunmurry Manor. In each case the whistleblowers alleged unsafe and poor nursing and care practice. In one case the whistleblower alleged that a twelve page letter of concerns about Dunmurry Manor had been sent to a named inspector in the RQIA. The whistleblower expressed surprise to have had no response to the letter. When this was raised with RQIA, it reported that it had not received the letter.

In late December 2016, the Commissioner was invited to a public meeting convened by Community Restorative Justice Northern Ireland, a community organisation, to discuss concerns about the alleged failures of care at Dunmurry Manor and more widely in other nursing homes in the area. The meeting was attended by the Chief Executive and Head of Legal and Policy Advice on behalf of the Commissioner. A senior official of the South Eastern HSC Trust and other HSC Trust's staff members were also in attendance along with representatives from the Health and Social Care Board, representing the Northern Ireland Adult Safeguarding Partnership (NIASP).

The meeting was well attended by family members of residents and patients from a number of nursing homes in the Dunmurry area. Many family members told of their relatives' experiences, some of which alleged significant and serious poor practice.

The Commissioner and Chief Executive sought assurances from the RQIA and the South Eastern HSC Trust that enhanced monitoring would be in place over the holiday period to provide additional support for residents and staff. The Commissioner and Chief Executive also met with a representative of the then Minister for Health in order to raise concerns about the ongoing situation in the home and to inform the Minister that the Commissioner was considering undertaking a statutory investigation.

When the three Failure to Comply Notices were not lifted at the end of January 2017 the 90-day period which the RQIA affords for sufficient improvements to be made, the Commissioner determined that it was necessary to carry out a statutory investigation into Dunmurry Manor and issued notices to the RAs on 15 February 2017. The purpose of the investigation was to examine the actions of the RAs in this case who have responsibility for ensuring the safe and effective care of residents in Dunmurry Manor and to establish the effectiveness and fitness for purpose of the legislation, policy and practice in place to ensure that care is fully compliant with the minimum standards for nursing care in Northern Ireland.

A summarised chronology of events and issues since the home opened in July 2014 until March 2017 is outlined in Appendix 4 of this report.

[42] The Nursing Homes Regulations (Northern Ireland) 2005 http://www.legislation.gov.uk/nisr/2005/160/made

Terms of Reference

A copy of the Terms of Reference for the investigation can be found at Appendix 1 of this Report.

In short, the purpose of the investigation was to gather evidence from older people's families, carers, staff working in the home (current and former), employees and appropriate staff from each of the RAs on their experience of the care and treatment received and the service provided at Dunmurry Manor.

The Commissioner was particularly interested in following the chronology of inspections by the regulator and the actions of the HSC Trusts and comparing those to the experiences reported by families of the care given to older people across the same timeframe.

Governance and Funding

The Commissioner is an arm's length body of government, sponsored by the Department for Communities (DfC). The Commissioner was not sufficiently funded to commence an investigation in the 4th quarter of 2016/17, and sought additional funds to undertake the investigation into Dunmurry Manor. The DfC provided additional funding throughout the investigation and was provided with regular updates on the progress of the investigation and the expenditure incurred. The DfC was not privy to evidence relating to the investigation but was kept informed of the progress of each phase. An observer from the DfC attends meetings of the Commissioner's ARAC (Audit and Risk Assurance Committee) where they are kept informed of and provide advice regarding the management of risks pertaining to the investigation.

Management of the Investigation Risk Register and reporting to ARAC

The inaugural use of the Commissioner's investigatory powers was considered sufficiently innovative and potentially contentious to be recorded, managed and reported to the ARAC through the Commissioner's Corporate Risk Register. Additionally, the operational risks of the investigation were managed through the project management process in a detailed and frequently revised operational Risk Register. The Commissioner and Senior Management considered and approved changes to the Risk Register at monthly meetings and on a quarterly basis sought the advice and guidance of the ARAC in the assessment, analysis and treatment of the risks therein.

In keeping with the requirement of the COPNI Act 2011 that the investigation must be conducted in private, members of ARAC were provided with updated versions of the Risk Register and changes were discussed at meetings. However, the papers were not circulated in advance nor were members permitted to retain the papers after the meetings.

The categories of risk expressed in the operational Risk Register included:

- Consequences of a failure to undertake the investigation
- Process failures in the exercise of investigatory powers
- Impact of the investigation on operational activity
- Stakeholder expectations
- Resilience and capacity of the Commissioner's investigation team
- Potential of adverse impact on ongoing Police Service of Northern Ireland (PSNI) investigations
- Maintaining privacy of the investigation including media attention
- Legal challenges by RAs to the use of investigatory powers
- Management of the budget and expenditure
- Security (physical/data/documents)

The operational risk register set out the Commissioner's approach to the investigation including the risk appetite, treatment of risks and the frequency of review.

Methodology

The COPNI Act 2011 at Schedule 2(2)-(4) sets out the legal framework under which the investigation was conducted. The investigation phases are summarised below:

Project Phases

Phase 1	Scoping
Phase 2	Setting Up investigation
Phase 3	Evidence Gathering Interviews Documentation requests
Phase 4	Consideration and Analysis of disclosed Information Triangulation of Evidence
Phase 5	Collation of Draft Findings Notification of draft findings to Relevant Authorities
Phase 6	Representations Process including the opportunity to cross-examine evidence
Phase 7	Drafting of report of investigation
Phase 8	Publication of investigation Findings and Recommendations
Phase 9	Post Project Evaluation

In preparation for a potential future use of the investigatory powers, six members of the Commissioner's team undertook BTEC Level 7 training in Advanced Investigative Practice, in 2016. This qualification included modules and assessments in a number of key areas including:

- Case Analysis
- Data Protection
- Cross Examination
- Investigative Interviewing
- Statement Report Writing
- Giving Evidence

The Investigatory process sought evidence in a range of formats:

- Documentation requested from each of the RAs
- Witness evidence from staff and former staff of Dunmurry Manor, families of residents and staff working within the RAs
- Some witnesses who did not wish to attend for interview provided comments via email and 27 individuals gave comments via phone. These witnesses were a mix of former staff of Dunmurry Manor and families of residents.

Evidence Gathering

At the outset, Runwood Homes Limited (Runwood) was asked to provide a range of contact information in order for the Commissioner to commence evidence gathering as part of the investigation. This information was requested under the Commissioner's legal powers and included the names and contact details of:

- Next of kin of current residents
- Next of kin of previous residents, including those who moved out and those who died
- Current and previous members of staff, including those from agencies
- Carers and volunteers who visited or provided support in Dunmurry Manor
- GPs and allied health professionals who attended residents at Dunmurry Manor

The Commissioner faced a range of challenges in obtaining this information from Dunmurry Manor. Much of the information received was incorrect or incomplete. Accurate and full information was essential if the Commissioner was to ensure that all families of residents and all staff were informed of the investigation and given an opportunity to express their views and bring forward any evidence.

There was a significant proportion of time spent by the Commissioner's staff clarifying inaccuracies and making further enquiries at the start of the investigation which led to a delay in the commencement of evidence gathering.

Throughout the course of the investigation the Commissioner was unable to have complete confidence that all next of kin and former staff were advised of the opportunity to come forward and contribute to the investigation. Posters were placed around Dunmurry Manor in an attempt to reach as many people as possible but obviously this would not have assisted in reaching those who were no longer involved with the home.

Information Requested and Received

R.A.	Information Requested and Received
DoH	Regional safeguarding and whistleblowing policies, the nursing home regulations and standards, correspondence from the South Eastern HSC Trust in relation to concerns raised at Dunmurry Manor. Information received within the timeframe requested.
RQIA	Correspondence relevant to the pre-registration stage of Dunmurry Manor, internal and external meetings about Dunmurry Manor, internal records and emails concerning Dunmurry Manor, incidents/complaints about Dunmurry Manor, and contemporaneous notes from inspections. Delayed by two months beyond timeframe requested; multiple additional assurances sought regarding data protection. Eight boxes of information provided in June 2017.
Dunmurry Manor / Runwood	Staff rotas and training records; Care Plans for selected residents, personnel files for staff, minutes and agendas from Residents'/Relatives meetings, staff meetings and Safeguarding meetings with Trusts; information received about complaints, concerns and incidents, and agendas of all meetings with the Trusts and the RQIA. Dunmurry Manor/Runwood acted through their legal team throughout the investigation; much time and correspondence was exchanged with limited information provided. No information was provided within the timeframe requested. After follow-up correspondence, documentation was provided in five different bundles between the end of June 2017 and the end of 2017.
SEHSCT[43]	Information requested was all provided two weeks after the deadline given. Additional assurances sought re data protection and a number of items were requested as the investigation progressed.
BHSCT[44]	All information provided and within the timeframe requested.
NHSCT[45]	All information provided and within the timeframe requested.
SHSCT[46]	All information provided with a slight delay from the timeframe requested.

[43] SEHSCT –South Eastern Health and Social Care Trust.
[44] BHSCT – Belfast Health and Social Care Trust.
[45] NHSCT – Northern Health and Social Care Trust.
[46] SHSCT – Southern Health and Social Care Trust.

Additional Material

Four individuals who were interviewed supplied additional material to the investigation including emails, minutes of relevant meetings, policies and procedures, and a covert video recording taken from within Dunmurry Manor.

Witness Evidence

119 full interviews were conducted, mostly between February 2017 and July 2017. A small number (five) of the interviews were conducted in September, October and November 2017. The table summarises the number of interviews by witness category for the 119 interviewees relating to Dunmurry Manor:

Witness Category	Number
Agency Staff	11
Department of Health	2
Current Dunmurry Manor staff	12
Former Dunmurry Manor staff	14
Families of current residents	16
Families of deceased residents	19
RQIA	18
Belfast HSC Trust	1
Northern HSC Trust	3
South Eastern HSC Trust	22
Southern HSC Trust	1

* *NB: Witness Category - refers to Interviewee status at time of interview and may have changed since.*

Most interviews were conducted in two hour time slots, usually at the Commissioner's office in Belfast. In a small number of cases interviews took place elsewhere, such as in interviewees' homes, in the event that it was not practical for the witness to attend the Commissioner's office.

Questionnaires based on a number of common themes were produced varying slightly depending on the different category of witness. In addition, each interviewee was given the chance at the end of the interview to state anything else they felt was relevant to the investigation or that they wished to comment on. In closing the interview, each witness was also offered the opportunity to make contact with the Commissioner's office if there was anything further of which they wanted to make the Commissioner aware.

Interviewees were provided with an information sheet about the investigation prior to the interview and again at the commencement of the interview.[47] In addition the Commissioner's investigating officers asked each witness to sign a consent form. Interviewees also gave their verbal consent to an audio recording being made of the interview for the purposes of assisting with typing and generation of an accurate written record. A small number of interviews were conducted by phone where relatives or other witnesses were not based in Northern Ireland.

All notes and recordings were stored in a secure location of the Commissioner's network system (accessible by only the investigation team) in line with the Information Management and Data Protection Process and Procedures.

[47] In a small number of cases some witnesses declined to sign the consent form and one declined to have the interview recorded.

Appendix 1: Glossary Of Terms

Accountability: The state of being answerable for one's decisions and actions. Accountability cannot be delegated.

Adverse incident: Any event or circumstance that could have or did lead to harm, loss, or damage to people, property, environment or reputation.

Advocacy: Advocacy supports and enables people who have difficulty representing their interests to express their views, explore and make informed choices and obtain the support they need to secure and uphold their rights. Advocacy is a fundamental element of equality, social justice and human rights.

Audit: The process of measuring the quality of services against explicit standards.

Bed-bound: Someone who is confined to bed, unable to be assisted to get up and someone who will frequently need assistance to be repositioned to avoid pressure ulcers.

Care home: A home for people with additional care and support needs, often described as a 'residential' or 'nursing' care home to specify the level of care provided. A residential care home will provide a room, shared living environment, meals and personal care and assistance (such as help with washing and eating). A nursing care home will provide similar support but will also employ registered nurses who can provide nursing care for people with more complex health needs.

Care manager: The person responsible for ensuring completion of the assessment of need, developing and co-ordinating the service user's care plan, for monitoring its progress and for staying in regular contact with the service user and everyone involved.

Care plan: The outcome of an assessment. A description of what an individual needs and how these needs will be met.

Care staff: Social care workers that are employed to assist and enable older people living in care homes through the delivery of personal care and support in their daily lives.

Care Standards: Set of standards published by the Department of Health for a variety of Health and Social Care settings, including Nursing and Residential Care Homes. Intended to be *"used by providers to set a benchmark of quality care and also by the RQIA in registering and inspecting nursing home services."* [48]

Compliance: Conforming with regulations or standards which have been set.

DoH / DHSSPS: Department of Health, formerly the Department of Health, Social Services and Public Safety.

Dunmurry Manor Care Home (Dunmurry Manor): A 76 bed residential and nursing home located in Dunmurry, Belfast, owned and operated by Runwood Homes. Specialising in dementia care, the home opened in 2014.

EMI (Elderly Mentally Infirm – now referred to as dementia). Dementia / EMI care homes are established to specifically care for older people who have mental health needs, such as dementia.

Enforcement: Enforcement action is an essential element of the responsibilities of RQIA and acts as a deterrent. Enforcement action is when a step is taken to encourage improvement and ensure compliance with regulations and minimum standards.

Governance: The system by which an organisation directs and controls its functions and relates to its stakeholders.

Hospital discharge: The process of leaving hospital after admission as an in-patient.

Health and Social Care Trust (HSC Trust): There are 6 HSC Trusts, one of which is the Northern Ireland Ambulance Service Trust. The other 5 (Belfast, South Eastern, Northern, Southern and Western) have responsibility for providing integrated health and social care services, including the provision of social care (much of this through placements in the Independent Sector). The Trusts have statutory obligations to establish arrangements for monitoring the quality of care being provided.

Needs assessment: A process whereby the needs of an individual are identified and their impact on daily living and quality of life, is evaluated, undertaken with the individual, his/her carer and relevant professionals. Also sometimes referred to as a care assessment.

Notice of Decision: Following the issue of a notice of proposal that has not been disputed by the provider, and where the service/provider has not yet achieved compliance with regulations, RQIA will issue a notice of decision to place conditions of registration on the service/provider. In this case the provider has right to make an appeal to the Care Tribunal within 28 days concerning any matter of dispute. Should no appeal be made, and where the provider has not achieved compliance with regulations, conditions of registration will be placed on the registration of the service/provider. During this period RQIA will continue to make an assessment of the provider's compliance with regulations and may lift the notice of decision if the provider has demonstrated sustained compliance/improvement in the service. It should be noted that while enforcement action is underway, RQIA may increase the level of inspection and monitoring at the service to ensure the safety and wellbeing of those using the service.

Notice of Failure to Comply with Regulations / Failure to comply notice: These are issued where RQIA has identified a serious or repeated breach in regulations. A formal notice is issued and compliance required within a stated timeframe, determined by the urgency of the matter (this can be no longer than 90 days). The provider can make written representation to RQIA within 28 days of issue on any point of law or fact regarding the notice. Where compliance is not achieved, further enforcement action may take place.

Notice of Proposal to Cancel, Refuse, Vary, Remove or Impose Conditions on Registration: Where a provider has significantly breached regulations or failed to address the improvements required within a notice of failure to comply with regulations, RQIA may move to propose to place conditions on the registration of the service/provider. The provider has right to make written representation to RQIA for a 28 day period concerning any matter of dispute. During this period RQIA will continue to make an assessment of the provider's compliance with regulations and may lift the notice of proposal if the provider has demonstrated sustained compliance/improvement in the service.

[48] DOH, 'Care Standards for Nursing Homes', p.4.

Patient records: The record of all aspects of the patient's treatment, otherwise known as the patients notes.

Police Service of Northern Ireland (PSNI): One of the lead agencies with responsibility for adult protection when there is an adult at risk of harm or in need of protection, and lead agency for the investigation of criminal investigation elements within these incidents. Protocol for Joint Investigation guides work with other relevant bodies on these types of cases.[49]

Prevention: An inclusive term that describes preventative interventions that can sustain and maintain people's health, wellbeing and independence.

Registered manager: The person in day to day charge of the service. The registered manager must have appropriate qualifications and experience.

Registered person/registered provider: A person deemed qualified to provide the service whose name appears on the certificate of registration. The registered person has overall responsibility for ensuring that the requirements of regulations and the associated standards are met. A company, committee or other group may be the registered person.

Representative: A person acting on behalf of a service user, who may be a carer, relative, or friend, or a formally recognised advocate.

Risk Assessment: The identification and analysis of risks relevant to the achievement of objectives.

Risk Management: The culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

RQIA: Regulation and Quality Improvement Authority

Runwood Homes Ltd: Runwood Homes Ltd is a private limited company, operating previously in England and Wales prior to opening operations in Northern Ireland. It was incorporated on the 30th July 1962, and has its registered office at Runwood House, 107 London Road, Hadleigh, Essex, SS7 2QL. The principal activity of the group is to provide high quality residential and day care services for older peoples' needs and those living with dementia or having a requirement for nursing care. The company operates 10 Residential and Nursing Homes in Northern Ireland ranging in size from 52-100 beds each, including Dunmurry Manor.

Serious Adverse Incidents: Serious injury to, or the unexpected/unexplained death, unexpected serious risk to a service user, unexpected or significant threat to service, serious assault (including homicide and sexual assaults) by a service user – on other service users, – on staff or – on members of the public occurring within a healthcare facility

Service user: A person who is receiving or is eligible to receive social care services. They may be individuals staying in their own homes, living in residential care or nursing homes, or being cared for in hospital.

[49] https://www.psni.police.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/adult-safeguarding-290617.pdf

Appendix 2: Notice to Relevant Authorities and interested parties of Commissioner's intention to conduct an investigation

Relevant authorities under investigation

To: Dunmurry Manor Care Home; Runwood Homes Limited;
Department of Health;
Regulation and Quality Improvement Authority;
South Eastern Health and Social Care Trust;
Belfast Health and Social Care Trust;
Northern Health and Social Care Trust;
Southern Health and Social Care Trust;

Interested parties

C.C. Police Service of Northern Ireland;
Royal College of Nursing;
Nursing and Midwifery Council;
Northern Ireland Social Care Council;
Patient and Client Council.

Proceeding under sections 4(3) and 4(4) of the Commissioner for Older People (Northern Ireland) Act 2011 (the "Act"), the Commissioner hereby puts you on notice of his intention to investigate the adequacy and effectiveness of law and practice relating to the interests of older people and the adequacy and effectiveness of services provided for older people by relevant authorities in respect of the care and treatment received and services provided at Dunmurry Manor Care Home under s.3(2), s.3(3) and Schedule 2 of the Act.

Terms of Reference

I have attached a copy of the Terms of Reference of the investigation for your information. If you wish to comment in relation to these please provide this to me on or before Friday 24th February 2017 (7 working days from date of Notice).

Evidence and Documentation

Please ensure that all relevant information and documentation held by you pertaining to Dunmurry Manor Care Home is secure and preserved for the duration of this investigation. I confirm that you will be formally contacted in relation to specific information, documentation and witness evidence that you will be required to provide.

I have appointed a number of experts to assist and advise me in this investigation. Evidence will be sought from current and previous residents, families, carers and staff members (present and past) of Dunmurry Manor Care Home. Evidence will also be invited from other allied health professionals associated with Dunmurry Manor Care Home and any other person who is interested in providing feedback on their experience of the care home.

The investigation shall commence on 15th February 2017 and shall take place in private. Relevant authorities under investigation will be given an opportunity to give oral or other evidence and will be provided with a draft report before publication of findings.

Eddie Lynch
Commissioner for Older People for Northern Ireland
14.02.2017

Terms of Reference for Investigation

Dunmurry Manor Care Home

An investigation into the care, treatment and experience of older people[50] living in Dunmurry Manor Care Home covering events leading up to the home's opening in 2014 until the end of the investigation (known as the "Review Period").

Proceeding under sections 4(3) and 4(4) of the Commissioner for Older People (Northern Ireland) Act 2011, the Commissioner intends to exercise his functions to investigate the adequacy and effectiveness of law and practice relating to the interests of older people and the adequacy and effectiveness of services provided for older people by relevant authorities in respect of the care and treatment received and services provided at Dunmurry Manor Care Home under s.3(2), s.3(3) and Schedule 2 of the Commissioner for Older People Act (Northern Ireland) 2011.

Specifically, the Commissioner will:

1. Seek evidence from older people, their families, carers and employees (present and past) and volunteers of their experience of the care and treatment received and the service provided at Dunmurry Manor Care Home by relevant external parties (known as "Relevant Authorities[51]")

2. Examine the circumstances and events (including evidence, allegations and /or disclosures (both anonymous and attributable)) including those made to Relevant Authorities and to the Commissioner in respect of the following areas:

   a. Due diligence completed by all relevant authorities prior to the opening of Dunmurry Manor Care Home and the commissioning of services by Relevant Authorities.

   b. Care planning – to include the assessment of health and social care needs, and the planning, delivery and evaluation of nursing care needs.

   c. The reporting and investigation of Adverse Incidents, Serious Adverse Incidents and safeguarding concerns including those which resulted in safeguarding cases and / or investigations under

[50] Older people (aged 60 yrs or over) residing in Dunmurry Manor Care Home includes both residential and nursing patients.

[51] Regulation and Quality Improvement Authority ("RQIA"), Dunmurry Manor Care Home ("Dunmurry Manor Care Home"), Runwood Homes Limited ("Runwood"), South Eastern Health and Social Care Trust ("SEHSCT"), Belfast Health and Social Care Trust ("BHSCT"), Northern Health and Social Care Trust ("NHSCT"), Southern Health and Social Care Trust ("SHSCT") and the Department of Health ("DOH") (together known as the ("External Parties").

the joint protocol between the Northern Ireland Health and Social Care Trusts and the Police Service for Northern Ireland.

d. Assessment of whistleblowing concerns and/or occurrences received, reported and/or brought to the attention of any of the Relevant Authorities.

e. Assessment of the number of complaints (verbal and written and whether expressed formally or informally) made to any of the Relevant Authorities and the management of these complaints.[52]

f. Assessment of all the inspection actions taken and enforcement actions taken by any and all Relevant Authorities.

g. Assessment of recruitment, retention and ongoing training and development of staff in Dunmurry Manor Care Home.

h. Assessment of the leadership and management practices of all Relevant Authorities and the impact of these on the experience of older people resident in Dunmurry Manor Care Home.

3. In respect of 2 above to highlight evidence of good practice, gaps and / or deficiencies in the actions / responses taken by any of the Relevant Authorities as well as any other body, person or organisation[53] which was notified or involved in any of the areas highlighted and associated learning from these events.

4. In the context of 1,2 and 3 above, consider and make recommendations as to whether the current legislation, policy and practice of nursing homes in Northern Ireland is effective in adequately safeguarding older people.

Inspection findings and required action

The Commissioner will publish recommendations that the Relevant Authorities and other public bodies subject to the investigation will be given an opportunity to comment upon.

[52] Complaints may be received from older people residing at Dunmurry Manor Care Home; families of older people residing in Dunmurry Manor Care Home; carers of older people residing in Dunmurry Manor Care Home; staff (both present and past and whether agency or employed) from Dunmurry Manor Care Home; allied health professionals who attended at Dunmurry Manor Care Home or who were associated with Dunmurry Manor Care Home and any other person or body who was associated with Dunmurry Manor Care Home during the Review Period.

[53] For the avoidance of doubt this will include, but not be limited to, General Practitioners / Doctors, the Royal College of GPs, Royal College of Nursing, the Nursing and Midwifery Council, the Northern Ireland Social Care Council, the Patient and Client Council and the Police Service of Northern Ireland.

Appendix 3:

Human Rights:

CSSIW's commitment to promoting and upholding the rights of people who use care and support services

As a regulator, CSSIW's primary responsibility is to ensure that the law in relation to the running of care services is upheld. The laws governing care services is primarily reflected through "regulations" and these have been carefully developed to incorporate human rights principles and legal requirements. The legal framework governing care anticipates and reflects people's rights. Therefore by assessing registrations, undertaking inspections and pursuing compliance with "regulations" CSSIW actively promotes and seeks to uphold people's legal human rights.

CSSIW also recognises that human rights legislation and practice is constantly evolving, moving beyond the point when regulations may have been made and that this needs to be reflected in the way we undertake our work. We have therefore developed inspection frameworks with guidance for our inspectors to place additional emphasis on the relevance and importance of human rights within our work.

In particular CSSIW has identified key lines of enquiry within its inspection framework to consider human rights principles and has set out examples of what is unacceptable care and considered to be a breach of people's rights and a breach of care regulations.

Where care is unacceptable CSSIW will always take enforcement action.

The basic framework of human rights

The concept of a set of basic human rights is relatively simple one however human rights law and practice is complex and changing. Not all rights are absolute, some are limited and others qualified and should be applied proportionately.

In addition in the areas CSSIW regulates and inspects there has been the development of additional law, charters and conventions, for example in relation to people with diverse backgrounds, children, people with disabilities, people who lack mental capacity and older people. Many of these restate fundamental human rights as set out in the European Convention of Human Rights, providing additional interpretation or additional areas for consideration.

CSSIW has developed a new inspection framework for regulated services based upon the principles of the Social Services and Well-being Act and the legal definition of "well-being". This definition includes the rights and protection of individuals. In future inspectors will undertake their inspections considering and reporting on four themes; People's Wellbeing, Quality of Care, Quality of Leadership and Management and Quality of the Environment where services are "setting" based.

The basic rights most applicable to social care are in the European Convention are set out below, mapped with reference to our inspection framework for regulated services.

Article	Inspection theme and potential lines of enquiry
Article 2: Right to life	**Wellbeing:** • Safe care • Adequate nutrition and hydration • Proper medical care • End of life planning and care **Quality of care:** • End of life planning and care **Quality of leadership and management:** • Steps taken to safeguard lives of people • Risk management; in all aspects but including infection control, behaviour management, management of self-harm.
Article 3: Not to be subjected to torture, inhuman or degrading treatment or punishment	**Quality of care:** • Proper medical care; esp. pressure area care • Continence care • The use of restraint • Quality of staff interactions **Quality of leadership and management:** • Culture of care • Response to complaints and whistleblowing • Safeguarding arrangements
Article 5: Right to liberty and security	**Quality of leadership and management:** • Proper application of DoLS **Quality of environment:** • Opportunities for freedom of movement and arrangements for security
Article 6: Right to a fair trial	**Quality of leadership and management:** • Fair application of staff disciplinary processes • Fair handling of complaints about people using service • Availability of advocacy

Article	Inspection theme and potential lines of enquiry
Article 8: Right to private and family life	**Wellbeing:** • People's ability to have choice and control; personal • autonomy • Privacy when people need/ want it • People's ability to be independent and live as normal a life as possible • People's ability to maintain relationships and links with the community **Quality of care:** • Experience of person centred and person directed care • Culture of enablement **Quality of leadership and management:** • Confidentiality and handling of personal data
Article 9: Right to freedom of thought, conscience and religion	**Wellbeing:** • People's ability to practice beliefs and follow religious practices
Article 14: Right of protection from discrimination	**Wellbeing:** • People's experience of discrimination, feeling valued and respected. • Support for cultural needs, diet, language, activities **Quality of care:** • Equality of access to care and support • Communication needs anticipated; language medium (Welsh and other languages) **Quality of leadership and management:** • Culture which promotes diversity and is responsive to differing needs **Quality of environment:** • Access and support arrangements

We have also set out what we believe are examples of good care as a result of people's rights being respected. The list is not exhaustive, but is illustrative of some of the more common concerns which arise.

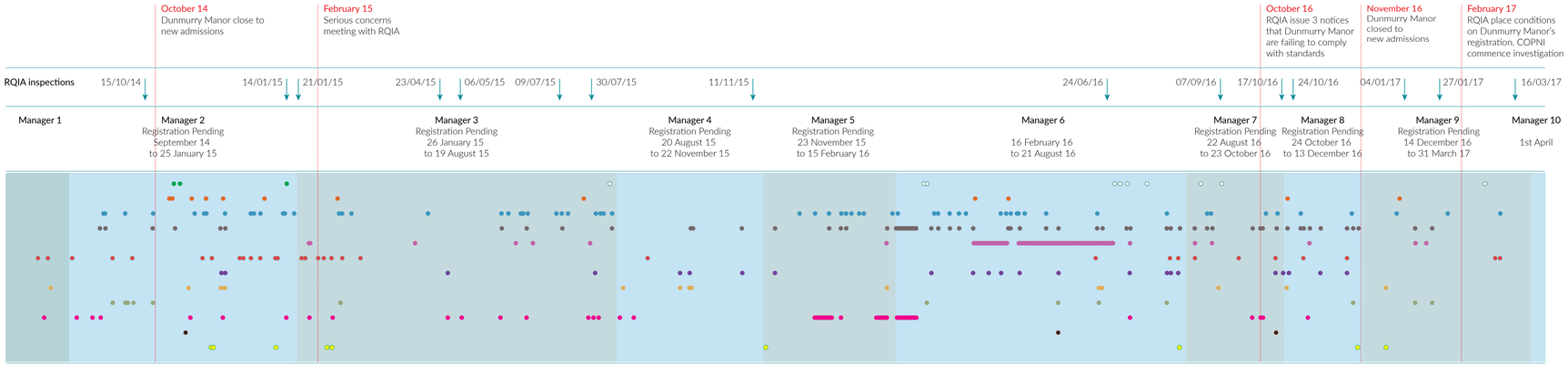
Article	Examples of unacceptable care	Examples of good care
Article 2: Right to life	People suffering from malnutrition or dehydration People suffering serious harm or dying because of inadequate care or failure to manage risks People not being able to receive medical care when they need it	**Supporting Wellbeing:** People feeling and being safe and protected from harm or neglect. **Quality of Care & Support Wellbeing:** People enjoying appropriate, healthy and nutritious meals and drinks. Mealtimes are appropriately spaced and flexible to meet people's needs. People supported to have enough to eat and drink. **Quality of Care & Support:** People being safe and as well as they can be because they receive proactive, preventative care and their wide range of needs are anticipated. Referrals made in a timely way to relevant health and social care professionals when people's needs change.
Article 3: Not to be subjected to torture, inhuman or degrading treatment or punishment	People living in unnecessary pain People being shouted at, verbally abused or physically or sexually assaulted People being mocked or made the subject of jokes	**Supporting Wellbeing:** People being encouraged to speak, express themselves and if necessary having advocacy support, are enabled to make choices, are being treated with dignity and respect and having their individual identities and routines recognised and valued. People's best interests being understood and promoted. People's independence being maximised by positive risk taking. **Quality of Care & Support:** People treated with kindness and compassion in their day to day care. People are offered warmth, encouragement and emotional support

Article	Examples of unacceptable care	Examples of good care
Article 5: Right to liberty and security	People being restrained or locked in without proper authorisation People being sedated unnecessarily People's belongings being stolen or misused	**Leadership & Management:** DoLS is used appropriately. There are robust, transparent systems in place to assess the quality of the service in relation to outcomes for people which includes feedback from people using the service and their representatives. **Environment:** There are opportunities for freedom of movement and arrangements for security. People are cared for in safe, secure, warm and well maintained surroundings. The need for privacy and confidentiality is anticipated and respected
Article 6: Right to a fair trial	People being given notice without justification or a fair hearing	**Leadership & Management:** Complaints are handled fairly, people living and working in or visiting the home know how to raise concerns, are supported to do so and these are acted upon.
Article 8: Right to private and family life	Intimate personal care being given in public view People not being supported to be well groomed and presented People not being consulted about the care and support they receive People not being afforded privacy when they need or request it People being denied visitors unless there is a good reason People's confidential information and data being shared inappropriately	**Supporting Wellbeing:** People being encouraged to speak, express themselves and if necessary having advocacy support, are enabled to make choices, are being treated with dignity and respect and having their individual identities and routines recognised and valued. **Quality of Care & Support:** People are fully involved in making decisions about the service they receive and the way they spend their time. **Leadership and management:** Are able to demonstrate that they consistently act with due diligence and care, have clear delegation of responsibilities and effective administration systems
Article 9: Right to freedom of thought, conscience and religion	People being mocked or criticised for their religious beliefs People being appropriate opportunities to follow their faith People's being given food not in keeping with their faith traditions	**Supporting Wellbeing:** People being encouraged to speak, express themselves and if necessary having advocacy support, are enabled to make choices, are being treated with dignity and respect and having their individual identities and routines recognised and valued. People being enabled to do things for themselves, maintain, recover and develop their individual skills, interests and beliefs.

Article	Examples of unacceptable care	Examples of good care
Article 14: Right of protection from discrimination	People suffering discrimination to a point where proper care is denied or they receive unfair, unequal treatment. People being mocked or criticised for their cultural background, sexual orientation or disabilities.	**Supporting Wellbeing:** People being encouraged to speak, express themselves and if necessary having advocacy support, are enabled to make choices, are being treated with dignity and respect and having their individual identities and routines recognised and valued.

Appendix 4

Chronology infographic for the period from the home opened in July 2014 until the tenth manager was appointed in March 2017 (one month after COPNI investigation commenced)



This graph includes records of all incidents in Dunmurry Manor from submitted evidence from Trusts, the RQIA, and testimony from interviewees. Incidents that threatened a resident's safety or the quality of care given to them included issues with medicine mismanagement, significant weight loss within an abnormal timescale, skin care and pressure sores, staff issues (including allegations against staff, problems resulting from poor staffing levels, poor practice by staff), neglect (issues of poor health or threatening behaviour by other residents that were not picked up quickly, treatment for issues not being given quickly enough), falls (residents suffering falls, unwitnessed falls, injuries from falls), cleanliness/essential equipment not working correctly or not being available, altercations (between residents, residents with staff or families), residents unaccounted for (residents exiting Dunmurry Manor without being stopped, Dunmurry Manor staff not being able to locate residents), unauthorised entries to rooms (concerns about residents entering other residents' rooms, sometimes being violent), unexplained injuries, sexual incidents (sexual assaults or incidents).

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