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

Home Truths:

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

Summary Report

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, case studies and findings of the investigation.

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.

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]."*

Resident R *(continued)*

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 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."*

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.

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.

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.

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

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.

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.'

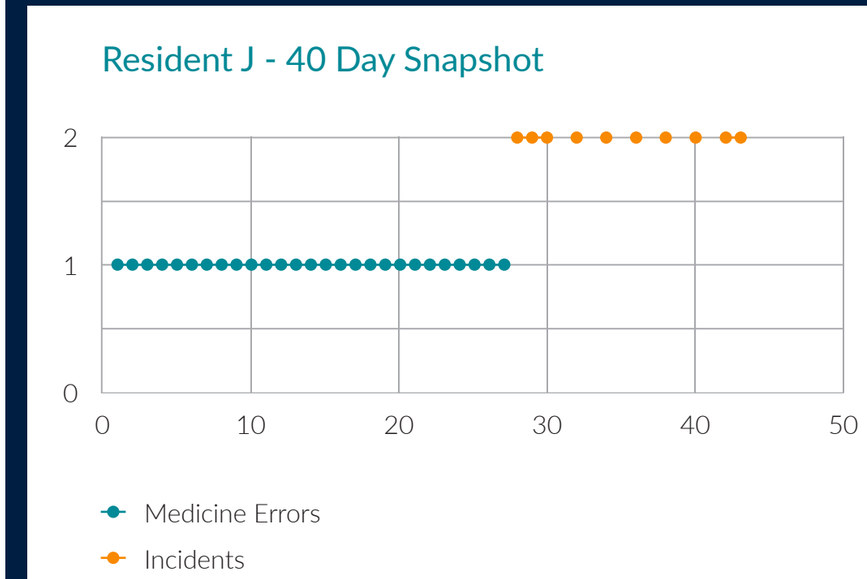
The HSC Trust staff member stated that Res J was displaying challenging behaviours and had numerous unwitnessed falls. At one stage ten unwitnessed falls were recorded in a three week period. Res J also entered a common room and displayed aggression. It was described that they 'hit all round' them. Res 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]



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.

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]

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.

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

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.

Re: RES J

A relative of Resident J 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 K

Resident K'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."

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.

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.

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."*

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.

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.

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.

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."*

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 of the full investigation report. 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.

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.

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.

Resident B *(continued)*

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.

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.

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.

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/*

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.

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

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 detailed from page 55 – 63 of this Summary 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 the full investigation 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 the full investigation 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 the full investigation 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 the full investigation 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.

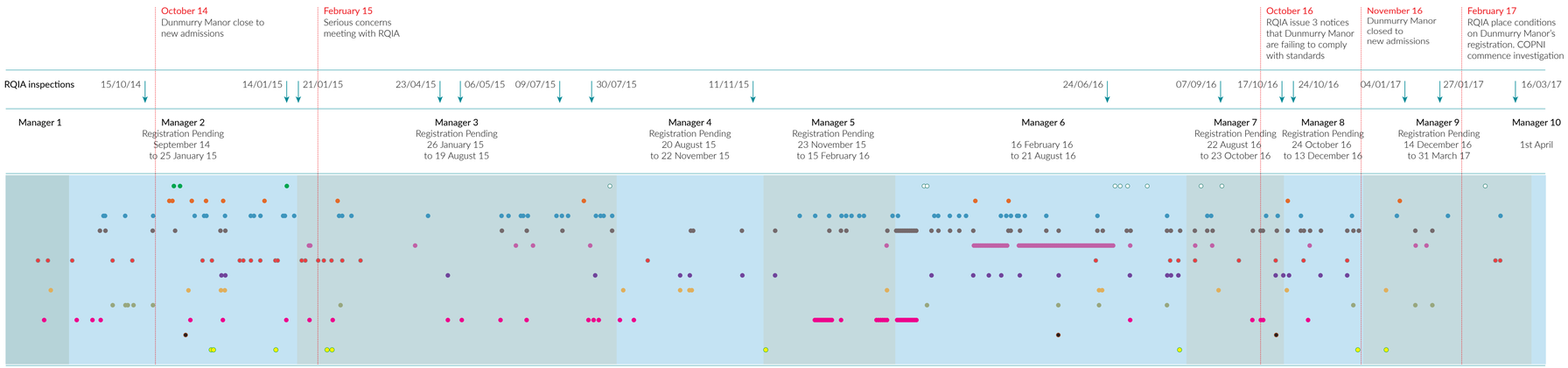
The Commissioner intends to hold meetings with the RAs with regard to implementation of the recommendations. This will provide an opportunity for the RAs to describe what they are doing and by when. One year after the publication of this report, the Commissioner will publish a report outlining the progress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

Appendix 1

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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