Independent Whole Systems Review

into Safeguarding and Care at Dunmurry Manor Care Home

Assessment and Care Management

December 2020

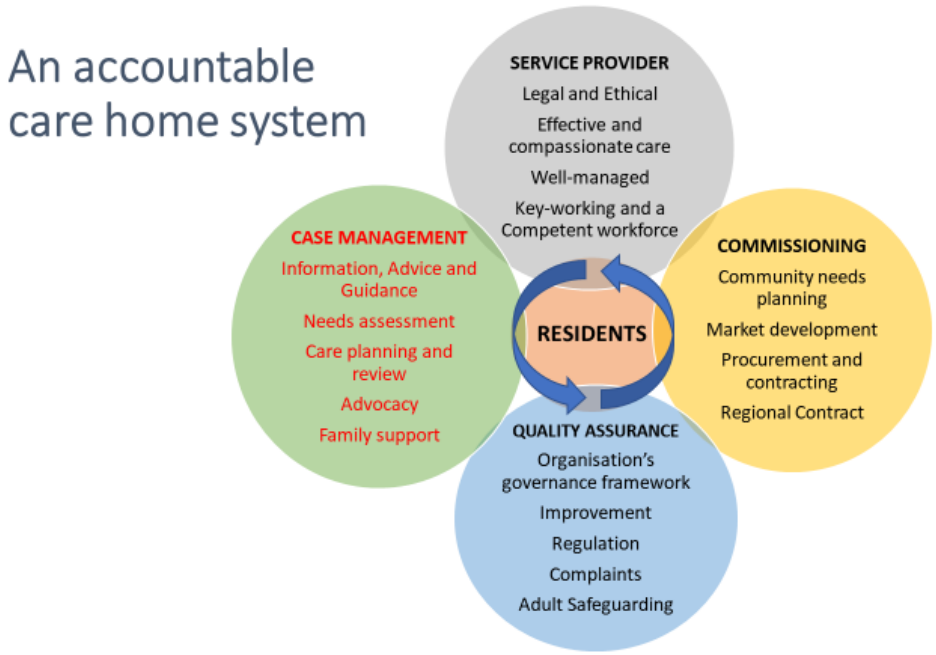
Evidence Paper: 4, Learning and Change Briefing, December 2020

Contents

Background

1. The Department of Health ("DH") of the Northern Ireland government commissioned CPEA Ltd ("CPEA") to undertake a "whole systems" review following the complaints of families concerning poor standards of care and support at Dunmurry Manor Care Home ("DMCH," owned by Runwood Homes Ltd).
2. Families approached the Commissioner for Older People in Northern Ireland ("COPNI") during December 2016, to express significant misgivings about the standards of care at the home. They reported that the care provider, the Regulation and Quality Improvement Authority ("RQIA"), the Health and Social Care Board ("HSCB"), the Health and Social Care Trusts ("HSCTs") and the Patient and Client Council ("PCC") had not addressed their complaints and they had nowhere else to go. In response, the COPNI used his investigation powers for the first time, requiring the DH, the HSCTs, RQIA and Runwood Homes to submit information for his consideration. He engaged an expert panel to advise him.
3. *Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home* ["Home Truths"] was published in June 2018. The report cited poor and inadequate personal care and inadequate assessments in relation to older people's skin integrity, continence, nutrition, pain, falls and, more generally, concerning risks and anticipatory care needs.
4. Families with relatives at DMCH and other homes in Northern Ireland were unsparing in their descriptions of the assessment and care management processes and how they perceived the actions of HSCTs' employees. Most typically they described feelings of powerlessness. This paper sets out their experience and perceptions and those of professionals in the five HSCTs, in care homes and other organisations. Although the assessment of individual needs is a common process across all professions and agencies, to be most effective it requires information about the procedures to be freely and easily shared. The remit of individual professionals responsible for assessing older people should be understood and there should be clear arrangements for people whose circumstances are most pressing. The *Review of Community Care – First Report*[1] (DHSS 2002) twenty years ago confirmed the importance of making, "proper assessment of need and good case management the cornerstone of high-quality care."
5. The position of assessment and care management in the context of the review of the whole system is shown in the graphic below. Simply fixing the problems associated with assessment and care management would miss the point. Hence the emphasis the Independent Review Team ("IRT") has placed on all parts of the systems.

[1] Annex A and B of Circular HSC (ECCU) 1/2010 show the relevant legislative and guidance context at the time



A Caveat

6. The families who approached the IRT were self-selected. That is, they initiated contact and/or were encouraged by relatives who had been introduced, and became known to the IRT, to make contact. The poor experience of families was not confined to DMCH nor to Runwood Homes. Their experiences were consistently bleak. The IRT does not take the view that these typify the experiences of all families with relatives in care homes in Northern Ireland. It met the staff of care homes who welcome family contact; who routinely promote shared sessions with nursery and primary school children; and homes from which the staff provide care and support to older people in their immediate neighbourhoods, for example. It is possible that the families with relatives in such care homes did not make themselves known to the IRT because their experiences were quite unlike those of the DMCH families whose stories received a great deal of media publicity in the wake of *Home Truths'* publication.

The story of "Philip Best"

7. The views, experiences and suggestions from and about older people and families are at the heart of this Review. Learning from them creates a compelling foundation for change. Several used terms such as "fighting" and "battling" and having to mobilise on a war-like footing to be heard by professionals. This was most apparent when a clinical decision was made that an older person was ready to be discharged from acute care. One family provided a clear window on the limitations of assessment and care management. It is presented in this Briefing Paper to illuminate how parts of health care, social care and housing might have worked differently to realise a different outcome for "Philip Best." The use of their story helps to convey the reality for families and sets out the real experience of being in the system of care in Northern Ireland. The identity of the older person has been protected and minor changes have been made to

ensure they cannot be identified. This account describes aspects of care that were shared with the IRT on many occasions.

Dad was a proud man. He was always well turned out and as he worked on cars, he was always conscious of getting oil off his hands. After our Mummy died, he was so lost. A part of him had gone. With the help of all of us, he started to turn the corner. He had many friends and was always happy. I have brothers and a sister in England who came across regularly to go out and about with him. Then he started to fade away a bit and left the taps on and was not doing the washing. I was worried and took him to the GP who found nothing wrong. He thought he was "tired." A few weeks later I went around and Dad was hot and flustered and in a mess. I took him to the hospital and he had a water infection [so] *they kept him in. He had only been in hospital once before for a hernia when he was young. This time it was different. He recovered slowly and was sent home; he was sent home on tablets. When he was in hospital, I told them his memory was going but they said it was the infection. When he got home, he stopped eating. I visited with meals and still he still wasn't eating.*

Dad was losing weight and we were all worried. I rang the GP who said, "bring him in." We did and he was referred to the hospital. [At the out-patients' department] *I was asked to sit outside and when Dad went in, he was looking very fearful. He came out and was upset. Afterwards I took him to his favourite place for some tea. He didn't know what was going on and no one at the hospital told me what was happening. I got a call from someone at the hospital who said he had to go for another appointment. The following day he fell at home and fractured his hip. We were so upset. We were all at the hospital…After the operation they told us he had to go to a care home as he was too much of a risk at home. They handed us a list of them. We didn't know what to do and hadn't even started when they said he had to leave hospital and a home had visited and he was going there to start with. We couldn't do anything or say anything and he was just taken there. We did what we could. I told him he would be coming home in a few weeks, but he didn't. He just went from bad to worse and then it was less than a week when they called us to say he was dying. On the Sunday night when I was there and my sister was on her way over from England, he died. I never told him what was happening and he didn't know he was to be in a care home from then on. I can't stop thinking about it and what went wrong. They never asked us about him about what he liked or needed or where he wanted to be. Afterwards, I thought it can't be like this usually and read about assessments. We didn't have those or if they were there, we didn't see them. I hope others don't get this treatment*

8. In the opening sentences, Philip Best's biography is glimpsed – a husband and father who worked on cars and whose life changed abruptly when he became a widower. With the support of his adult children and a network of friendships, his disrupted world changed and he recovered happiness once again. Such personal knowledge is especially valuable when a person is physically and mentally compromised. In combination with clinical knowledge, an understanding of a person's embeddedness in relationships, their routines and engagement in activities and what matters to them - which can inform the work of health and social care

professionals. The quality of relationships with professionals is fundamental to the delivery of valued care and support.

9. When Philip Best's adult children noticed that he was becoming forgetful, they accompanied him to his GP. This marked the beginning of a challenging time for them as they sought to explain where his familiar and typical behaviour ended and his troubling behaviour began. Even though relatives may be reluctant to acknowledge what such episodes of behaviour mean, they become drawn into the worlds of GPs, acute hospital care, psychiatrists, community services and care homes.
10. Several families used terms such as "desperate," "hopeless" and "despondent", many reported sleep disturbance, grief and being locked into cycles of anxiety. They explained that the lack of control and involvement in what was happening to their relatives "engulfed" their lives.
11. A person with a relative at DMCH explained, *We have had to battle with most parts of the system.* Another family carer recalled, *I was not listened to about my Mum's likes and dislikes and I know her more than the professionals who think they know best and they do not.*
12. Philip Best's adult children accepted the GP's preliminary diagnosis that their Dad was tired. They took immediate action when his behaviour became unrecognisable. The family's contact with clinicians during his first hospital admission did not bode well. It did not appear that their experiential knowledge of supporting their Dad was of interest when information about his failing memory was attributed to his Urinary Tract Infection. There appeared to be no interest in ensuring Philip Best's safe hospital discharge since the family were not invited to be part of the discharge planning process. If they were perceived by professionals as the primary care-givers, they shared the experience of all the families with whom the IRT has had contact and were not offered an assessment in their own right.[2]
13. Getting assessment right has been a unifying concern in Northern Ireland for many years. For example, the DHSS' (1991) paper, *People First: Community Care in Northern Ireland for the 1990s* emphasised the requirement, "within available resources, to identify and assess individuals' needs, taking full account of personal preferences (and those of informal carers), and design packages of care best suited to enabling the consumer to live as normal a life as possible;" and the DHSSPS (2010) circular about care management stated, *Health and Social Care (HSC) staff need to work in partnership with service users and carers to explore choices, identify and assess risks and agree on how these will be managed and minimised for the benefit of individual service users, carers, families and communities.* It does not appear that Northern Ireland's structural integration of services across five HSCTs has realised the benefits of holistic needs' assessments, timely interventions, rapid responses to crises and investment in understanding older people's wishes and preferences.
14. Philip Best's GP took action as a result of his weight loss and his family's concerns and a hospital appointment resulted. Although he was fearful, his family was excluded from the consultation. Families' experience of being excluded was recounted to the IRT on many occasions. Visits to memory clinics were characterised by the people closest to the older person being left outside

[2] The Carers and Direct Payments Act (2002) places an obligation on HSCTs to inform carers about their right to an assessment

consultation rooms, wondering what was happening. At the end of these consultations, no-one explained the outcomes or next steps. In one case the IRT were told:

My Dad was such a private man. His family had been badly affected through the years and he didn't share much. He was a working man and saw doctors as being way above him. I know he wouldn't have told them anything or answered questions if I was not with him to reassure him it was alright to do so. When we found he had probable dementia and I asked about it, I was told he couldn't answer the questions he had been asked. I was so upset.

15. The experience of Philip Best is being repeated across Northern Ireland today. Returning to his life, he was distressed at the end of the consultation and his inability to recall the salient points bewildered his adult children. Philip Best's fall at home pre-empted a second out-patients' appointment, resulted in surgery and the statement that because he was "too much of a risk at home" he would have to move into a care home. These decisions were made independently of Philip Best and his family who had expected some involvement. Although no professional had accompanied him to his home to assess his self-care activities there, the generic and unassessed risks were deemed too great. Where was the social work input? Where were the Occupational Therapists, Physiotherapists and specialist nurses that could have made a difference to his life?
16. The 2002 Circular advanced the Northern Ireland Single Assessment Tool ("NISAT") and described the functions of care management, including *determining the level of assessment* [required]…*undertaking a proportionate, person-centred assessment of the individual's needs having due regard to the needs of carers; developing and implementing a care plan and care package…to meet identified needs; and monitoring, reviewing and adjusting the care plan and care package as required.*
17. Philip Best and his family did not experience competent assessment and were directed to identify a home from a listing provided. This unfamiliar task became unnecessary when they were told that a place was available in a care home and discharge had been arranged. Disorientated as they were, the family were wholly incidental to Philip Best's admission to residential care. There was nothing person-centred about this experience. He was not given the opportunity to benefit from rehabilitation and recuperation and if there was a professionally identified goal for him, it remained a secret. No one explained the place of competent and ongoing assessment in care management; rehabilitation therapies and/or intermediate care to expedite appropriate hospital discharge and avoid premature admission to a care home; these were not proposed. There was no one on their behalf asking questions of the professionals' decision-making. One outcome is that incomplete and poor-quality information concerning older people's support needs is shared with care homes.
18. An acute hospital is not a good place to be whilst waiting for care arrangements to be made. Hospital-based social workers, nurses and care homes staff and managers confirmed this. They noted:
    - *This is about quick discharges and not always about their medical condition. We would not see this happening like this in other age groups. Older people are being penalised and*

seen as a problem with blocking beds. We know that quick discharges lead to people being readmitted very quickly.

- *"Medically fit for discharge" means "free up a bed." It's difficult to challenge.*
- *It's about numbers and not patients.*
- *We can receive several calls asking us urgently to go to the hospital to carry out a pre-admission assessment. Staff from the ward will regularly ring and say "it is urgent you attend."*

Strategic priorities

19. The Chief Social Work Officer has established a working group on Adult Social Care Reform that is led by the Deputy Chief Social Worker, with the lead officer for older people, to implement *Power to People* and reform (or "reboot") adult social care. It has five strategic priorities which are:
    - Valued workforce
    - Individual choice and control
    - Prevention and early intervention
    - Supporting carers
    - Primacy of home
20. Insofar as assessment and care management is concerned there are plethora of strategic actions that are necessary *to ensure the individual has control over the decisions affecting their social wellbeing and their care and support needs.* The main Evidence Paper offers a series of POINTS to CONSIDER in learning and changing adult social care. The analysis of findings in respect of assessment and care management, the story of "Philip Best" is instructive, and proposed actions are derived from the experiences of residents and families at Dunmurry Manor. They have been tested and challenged more widely in the field.

Analysis

21. The older people and families who sought to share their experiences as part of the Review were not advantaged by the inter-professional corroboration expected of integrated HSCTs. Integrated services should improve a person's experience of services and yet families highlighted insensitivity, harm and neglect as impacts of their relatives not receiving adequate, timely and compassionate care. Families' experiential knowledge appeared to be set aside in favour of custom and practice.
22. There is a strong sense that integration is underdeveloped at many levels, particularly in terms of: ensuring access to advice and help; individual assessment; delivering the help required; limiting unnecessary bureaucracy; and providing opportunities for individuals and their families to control what happens. The IRT was told by social workers, in both hospitals and HSCTS, that the profile of the type of casework necessary is weak despite the integration of health and social care services.
23. Families who are anxious about the health crises of older relatives are not sophisticated users of health and social care services. They want (i) a single gateway to information, advice and possibly advocacy to understand their relatives' conditions, expected treatment and

implications for returning home, for example; (ii) knowledgeable and responsive professionals who do not expect them to solo 'navigate' the service system; (iii) evidence that they, and their relatives, are expected to be involved in decision-making;[3] and (iv) familiarity with care and support options - and optimism about these.

24. Effective long-term conditions' management is underpinned by a holistic assessment of needs. In crisis, older people are susceptible to falls and confusion. Viable and valued ways of supporting older people result from assessments of needs, strengths and presenting conditions. Such detailed understanding of a person's circumstances is required if effective interventions and outcomes are to result.
25. Although families described the undue haste with which they were expected to make decisions about identifying a care home in readiness for hospital discharge, they did not describe the efforts of HSCTs to avoid or reduce hospital admission. Yet once admitted to hospital, families described how their relatives' independence diminished. This resulted in inaccurate assessments which did not reflect their relatives' biographies or strengths.
26. Respondents to the Review were confused about the powers and the responsibilities of HSCTs and RQIA. Social work staff, nurses and managers within the HSCTS commented that they are left to pick up the work of RQIA, without having the powers to do so. An example of this is when RQIA issue a Failure to Comply Notice it is the HSCT who are asked to make the visits to carry out checks which may be at the weekends. The general view was RQIA should make the checks on notices and assess compliance.
27. Not all families were familiar with RQIA's inspections of care homes. They did not recall being encouraged to visit homes prior to their relatives being placed and were mostly unaware that (i) the homes' responsibility for producing a personal/care plan is mandated by the nursing/residential home regulations[4] to ensure that the home can meet a person's needs; (ii) financial assessments were required and that contributions from the family may be required; (iii) information for the initial care plan should be derived from the combination of the care manager's and the home's pre-admission assessments; (iv) care reviews occurred.
28. An initial review at six weeks is considered best practice. Although there are circumstances where flexibility is required, it does not appear that care reviews are being undertaken with the frequency and rigour required. HSCTs need to support the person in a care home placement by a first review that confirms the placement. It should ensure that financial assessments are understood by families – concerns about funding are addressed in Evidence Paper 5. Thereafter, the care manager should ensure that the person's needs continue to be met. The IRT was told of reviews being undertaken by managers over the phone
29. There are opportunities for care homes to be inclusive of people with a range of care and support needs - with access to nursing and allied healthcare as required. Nurses play a crucial role in ensuring older people have fulfilling lives and their health care and nursing needs are

[3] Although it might be expected, it should not be assumed that all families would wish to be involved. Nor should it be assumed that all relatives have equal standing and hold a shared view about the older person's support needs

[4] Even when an older person pays for their own care and chooses not to access care management, the care home provider/manager must carry out a pre-admission assessment.

met. The input of nurse specialists in diabetic care, tissue viability, and continence care, for example, can make a real difference to the quality of life and health status of an older person. The input of nurses is likely to acquire a higher profile in the sector, in the post-pandemic era, given their investment in teamwork to address infection control and prevention and support for homes.[5] There is considerable variation across HSCTs concerning nursing in-reach to homes. Neither nursing strategy documents[6] nor more general workforce strategies have resulted in a consistent approach.

Proposed Actions

a) Build on improvements in intermediate care services by making an explicit investment

Two questions merit consideration: (i) What services do you need to have in place so that no older person admitted to hospital from their own home is discharged directly to long term care?[7] (ii) What intermediate care services do you need to have in place so that older people may be assessed in a setting other than hospital? There is a strong sense that integration is not working well at many levels, particularly in terms of: ensuring access to advice and help during crises; individual assessment; delivering the help required; limiting unnecessary bureaucracy; and providing opportunities for individuals and their families to control what happens. It was not clear to families that older people's care was being managed or that their own contributions to caregiving merited a carer's assessment.

b) Provide a single gateway to information, advice and guidance

The experience of older people defines the effectiveness of service responses. Families who are anxious about the health crises of older relatives are not sophisticated users of health and social care services. They want (i) a single gateway to information, advice and possibly advocacy to understand their relatives' conditions, expected treatment and implications for returning home, for example; (ii) knowledgeable and responsive professionals who do not expect them to solo 'navigate' the service system; (iii) evidence that they, and their relatives, are expected to be involved in decision-making;[8] and (iv) familiarity with care and support options - and optimism about these.

One way to do this is to prepare anonymised case studies to provide families with real examples of the range of people's pathways from acute care.

[5] The IRT is aware of work underway to enhance clinical care for residents in care homes and to review intermediate care including standardising nursing in reach. However, the IRT completed its fieldwork in March 2020 and the Paper was drafted in December 2020.

[6] Evolving and Transforming to Deliver Excellence in Care: A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015-2025); A District Nursing Framework 2018-2026: 24 Hour District Nursing Care No Matter Where You Live; Nursing Now NI Campaign Jan 2019

[7] A question asked by the Health and Social Care Change Agent Team. Department of Health (2003) *Changing Places: report on the work of the Health and Social Care Change Agent Team 2002-03* London: DH

[8] Although it might be expected, it should not be assumed that all families would wish to be involved. Nor should it be assumed that all relatives have equal standing and hold a shared view about the older person's support needs

c) Reformulate the remit and functions of the Patient and Client Council (PCC)

In Evidence Paper 2 on Complaints, it was proposed that the PCC should reassert the primacy of advocacy for complainants.

There is scope for the PCC to explore with older people and their relatives how independent advocacy should be given expression in a refreshed complaints system, and to assist with collective and individual grievances. Advocacy has a place in supporting older people and families when needs are being assessed and reviews undertaken to advance people's best interests and ensure human rights. Attending to the voice of older people has democratic validity because it reveals how services are provided and how they are used.

d) Ensure a consistent approach to assessment and care management and set standards

Negotiations should commence to bring working practices together and curtail variation across the HSCTs.

Effective long-term conditions' management is underpinned by a holistic assessment of needs. In crisis, older people are susceptible to falls and confusion. Viable and valued ways of supporting older people result from assessments of needs, strengths and presenting conditions. Such detailed understanding of a person's circumstances is required if effective interventions and outcomes are to result.

Home Truths referred particularly to care reviews, their timing after admission to a care home and their subsequent frequency. Standards or good practice guidance should be enshrined in the admission care plan,[9] built into an individual's contract, checked as good practice and sampled at inspection. There is an argument for inspecting the assessment and care management practice of HSCTs. The first care review after admission to a care home should confirm the acceptability and adequacy of the placement. An onward care plan should be formulated for future reviews including identification of what might be an indicator for an earlier review taking place.

e) Introduce a 'tenure agreement'

This could be achieved through an addendum to the Regional Contract - personal to each resident - which recognises their care plan within a 'tenure agreement.'[10]

Care home managers stated that the most typical referrals for care home placements are from hospitals. The responsibility for identifying a home was delegated to families who described the experience as distressing, rushed and made even worse because of inadequate information. Although some families were able to visit a couple of homes, there was no opportunity to make considered decisions.

[9] Decisions about the arrangements for sharing care plans – which are personal to each resident - should be part of the admission and care planning processes

[10] Evidence Papers 5 and 6 address the questions of contracts and rights of tenure.

f) Practice collective and pragmatic leadership

There is considerable variation across HSCTs concerning training and workforce issues. A good example is the differences in approach to nursing in-reach to homes.[11] The input of nurse specialists in diabetic care, tissue viability, and continence care, for example, can make a positive difference to the health status and quality of life of an older person.

Neither nursing strategy documents[12] nor more general workforce strategies have resulted in a consistent approach across the HSC Trusts.

The enhanced health care approach led by nurses and clinical staff can lead to people being 'labelled' by their health condition such as the 'person with dementia' and not viewed as a whole person with families and interests. Whilst people living in care home are entitled to the best of health care in a timely way, care homes are not clinical settings and nor should they be. The IRT endorse leadership which stresses the 'Primacy of Home' and what that means to people living and working in such settings. Care and support must take into account people's interests, relationships and dreams and this will not be achieved by just focusing wholly on health.

There are common training needs for care managers, registered managers and inspectors. This requirement transcends individual professional categories and instead, focuses on the essential training and leadership needed to ensure effective care for older people. The requirements to work in a multi-disciplinary team would be more easily delivered if interagency, multi-professional training were embedded in a system designed to take account of the scale of demand. Such a system would require consideration of career structures with the introduction of seniority as a legitimate objective. The work of Allied Health Professionals would gain greater recognition if this were adopted. In strategic planning terms, the care of older people is likely to become an even larger part of the work of the DH. The growth in care homes with dementia registered places demonstrates the rising need for such provision.

The NISCC, NIPEC as well as the RCN and other Trades Unions should be centrally involved in workforce planning and training and should build on the *Rapid Learning Initiative*[13] with families, care home providers, IHCP and managers. There are opportunities for care homes to be inclusive of people with a range of care and support needs - with access to nursing and Allied Healthcare Professionals, as required. The input of nurses is likely to acquire a higher

[11] The IRT is aware of work underway to enhance clinical care for residents in care homes and to review intermediate care including standardising nursing in-reach. However, the IRT completed its fieldwork in March 2020 and the Paper was drafted in December 2020.

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[13] The 17 June 2020, *New Framework Planned for Nursing and Medical Input into Care Homes* and 24 June 2020, *Work underway to learn from care home Covid-19 experiences*

profile in the sector, in the post-pandemic era, given their investment in teamwork to address infection control and prevention and support for homes.

Workforce leadership and management in care homes is an employer and registered provider's responsibility. Professional regulators could have a more significant role if registration was based on qualifications according to a job role. It is a concern that some of the named organisations set down 'rules' that may be difficult for providers to meet. Codes of conduct, standards and guidance are helpful, but they need to be enshrined in regulation and funded to be enforceable.

For example, the IRT considered drafts of delegation of duties which were restrictive of employer's duties and likely to cause staffing issues. The enabling role of DH using the RQIA should be seen as a supportive aid to improvement. It is important that DH has an overall view of the workforce in NI across health and social care sectors. Data is the foundation of workforce leadership and management – for planners, commissioners and employers. It was disappointing that during the Review there was no meaningful workforce data available.

g) Learn, change and improve through data and information

Since too much information gathering is duplicated and unevenly and inconsistently collected it makes sense to identify 'signals' of how well commissioning, assessment and care management are functioning. This is a model which is replicated in Evidence Paper 1 on Adult Safeguarding. The task is one that should be undertaken with residents, families and practitioners. The importance of building commissioning models based on neighbourhood /local/community planning, cannot be over-emphasised. Individual data can be aggregated to plan for supply to meet demand rather than demand to fit supply. Outcomes-based assessment and care planning are essential to effective commissioning. Questions such as; did people get what they wanted /needed? And, were they satisfied? are fundamental. The information gathered may be used to identify signs of success - the 'signals'.

The task is not to generate hundreds of 'signals', but rather ones that highlight residents' and families' experiences. This is not to reinforce or duplicate performance management data and information but rather to sharpen the focus on what matters to care home residents and their families in assessment and care management. For example, it matters to people that they and their families are involved in assessment, that an admission to a care home considers the loss and change entailed, that family members contribute to care plans and reviews and their individuality and strengths – what they can contribute – are recognised.

The question is: how data and information might be useful to commissioning, assessment and care management in terms of (i) relevance, (ii) accuracy and reliability (iii) timeliness (iv) accessibility and clarity and (v) coherence and comparability.

h) Set out the remits for monitoring quality in care home services

Care home providers are responsible for the quality of the whole service and of residents' care plans. The regulator is the primary monitor of care home providers and the HSCTs care

managers monitor the care plans of individual residents. The regulator, registered managers and care managers must work together to avoid duplication and omission.

However, across the HSCTs, social workers, nurses and allied health professionals identified a major part of their work as *monitoring care homes.* This has eclipsed assessments and care reviews to the detriment of residents and strays into inspection's territory. The capacity of professionals to impact on outcomes appears to be greater in local, closely specified collaborations. For example intervention by HSCTs in the running of DMCH was not the foundation for sustained improvements.

Concluding statement

30. Social work and health care begins with assessment. A detailed assessment of presenting problems – and strengths[14] – and the contexts which may exacerbate or mitigate these should be central to discussions with older people and their families. They want (i) effective "history-taking" which encourages practitioners to use reflection and to respond with empathy (ii) account taken of other, relevant assessments (iii) and an expectation of their willingness, and that of their relatives, to participate fully.
31. The importance of clarifying the remit and legal powers of the RQIA and the HSCTs was identified in Evidence Paper 1, Adult Safeguarding and Evidence Paper 3, Regulation and Inspection. Since care homes' staff question the monitoring activities of HSCT personnel, clarification requires attention since it has become an enduring challenge. The interface between HSCTs' professionals assessing and reviewing older people's care and support and RQIA inspectors issuing failure to comply notices concerning breaches of care standards should not weaken the capacity of both to serve older people.
32. The IRT concludes by re-emphasising that it is the care home providers and managers who are responsible for providing high-quality standards to really meet people's individual needs. Within such clarity, greater priority can be given to creating opportunities for families to 'share the care' for the person in the care home.

[14] Often known as strength or asset-based assessment