



LAW REFORM
COMMISSION/COIMISIÚN UM
ATHCHÓIRIÚ AN DLÍ

CONSULTATION PAPER

LEGAL ASPECTS OF CARERS

(LRC CP 53 – 2009)



LAW REFORM
COMMISSION/COIMISIÚN UM
ATHCHÓIRIÚ AN DLÍ

CONSULTATION PAPER

LEGAL ASPECTS OF CARERS

(LRC CP 53-2009)

© COPYRIGHT
Law Reform Commission

FIRST PUBLISHED
July 2009

ISSN 1393-3140

LAW REFORM COMMISSION'S ROLE

The Law Reform Commission is an independent statutory body established by the *Law Reform Commission Act 1975*. The Commission's principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify and modernize the law. Since it was established, the Commission has published over 140 documents containing proposals for law reform and these are all available at www.lawreform.ie. Most of these proposals have led to reforming legislation.

The Commission's role is carried out primarily under a Programme of Law Reform. Its *Third Programme of Law Reform 2008-2014* was prepared by the Commission following broad consultation and discussion. In accordance with the 1975 Act, it was approved by the Government in December 2007 and placed before both Houses of the Oireachtas. The Commission also works on specific matters referred to it by the Attorney General under the 1975 Act. Since 2006, the Commission's role includes two other areas of activity, Statute Law Restatement and the Legislation Directory.

Statute Law Restatement involves the administrative consolidation of all amendments to an Act into a single text, making legislation more accessible. Under the *Statute Law (Restatement) Act 2002*, where this text is certified by the Attorney General it can be relied on as evidence of the law in question. The Legislation Directory - previously called the Chronological Tables of the Statutes - is a searchable annotated guide to legislative changes. After the Commission took over responsibility for this important resource, it decided to change the name to Legislation Directory to indicate its function more clearly.

MEMBERSHIP

The Law Reform Commission consists of a President, one full-time Commissioner and three part-time Commissioners.

The Commissioners at present are:

President:

The Hon Mrs Justice Catherine McGuinness
Former Judge of the Supreme Court

Full-time Commissioner:

Patricia T. Rickard-Clarke, Solicitor

Part-time Commissioner:

Professor Finbarr McAuley

Part-time Commissioner:

Marian Shanley, Solicitor

Part-time Commissioner:

Donal O'Donnell, Senior Counsel

LAW REFORM RESEARCH STAFF

Director of Research:

Raymond Byrne BCL, LL.M (NUI),
Barrister-at-Law

Legal Researchers:

Chris Campbell B Corp, LLB Diop sa Gh (NUI)
Frances Colclough BCL, LL.M (NUI)
Siobhan Drislane BCL, LL.M (NUI)
Claire Murray BCL (NUI), Barrister-at-Law
Gemma Ní Chaoimh BCL, LL.M (NUI)
Brid Nic Suibhne BA, LLB, LL.M (TCD), Diop sa Gh (NUI)
Jane O'Grady BCL LLB (NUI), LPC (College of Law)
Gerard Sadlier BCL (NUI)
Joseph Spooner BCL (Law with French Law) (NUI), Dip. French and
European Law (Paris II), BCL (Oxon)
Ciara Staunton BCL LL.M (NUI), Diop sa Gh (NUI)

STATUTE LAW RESTATEMENT

Project Manager for Restatement:

Alma Clissmann, BA (Mod), LLB, Dip Eur Law (Bruges), Solicitor

Legal Researchers:

John P. Byrne BCL, LL.M (NUI), PhD (NUI), Barrister-at-Law
Elizabeth Fitzgerald LLB, M.Sc. (Criminology & Criminal Justice),
Barrister-at-Law
Catriona Moloney BCL (NUI), LL.M (Public Law)

LEGISLATION DIRECTORY

Project Manager for Legislation Directory:

Heather Mahon LLB (ling. Ger.), M.Litt, Barrister-at-Law

Legal Researchers:

Margaret Devaney LLB, LL.M (TCD)
Rachel Kemp BCL (Law and German), LL.M (NUI)

ADMINISTRATION STAFF

Head of Administration and Development:

Brian Glynn

Executive Officers:

Deirdre Bell

Simon Fallon

Darina Moran

Peter Trainor

Legal Information Manager:

Conor Kennedy BA, H Dip LIS

Cataloguer:

Eithne Boland BA (Hons), HDip Ed, HDip LIS

Clerical Officers:

Ann Browne

Ann Byrne

Liam Dargan

Sabrina Kelly

PRINCIPAL LEGAL RESEARCHER FOR THIS CONSULTATION PAPER

Frances Colclough BCL, LL.M (NUI)

CONTACT DETAILS

Further information can be obtained from:

Head of Administration and Development
Law Reform Commission
35-39 Shelbourne Road
Ballsbridge
Dublin 4

Telephone:

+353 1 637 7600

Fax:

+353 1 637 7601

Email:

info@lawreform.ie

Website:

www.lawreform.ie

ACKNOWLEDGEMENTS

The Commission would like to thank the following people who provided valuable assistance:

Dr. Lucia Carragher, Netwell Centre

Mr. Andrew Fagan, Health Information and Quality Authority

Ms. Geraldine Fitzpatrick, Department of Health and Children

Dr. Maureen Gaffney, National Economic and Social Forum

Ms. Ann Marron, Netwell Centre

Dr. Anne-Marie McGauran, National Economic and Social Forum

Mr. Michael Murchan, Department of Health and Children

Full responsibility for this publication lies, however, with the Commission.

TABLE OF CONTENTS

INTRODUCTION	1	
CHAPTER 1	REGULATION OF PROFESSIONAL HOME CARE PROVIDERS AND REFORM OPTIONS	5
A	Introduction	5
B	Professional Health Care at Home	5
C	Methods of Delivery of Professional Home Care	8
	(1) HSE Home Help Services	8
	(2) HSE Home Care Support Scheme	9
	(3) Private commercial agencies	10
	(4) Informal carers	10
	(5) Conclusion	11
D	Regulation of other care professionals	11
	(1) Regulation of residential care providers	11
	(2) Health and Social Care Professionals Act 2005	15
	(3) Conclusion	18
E	Regulation of domiciliary care providers	18
	(1) Function of HIQA	19
	(2) Role of the Office of the Chief Inspector of Social Services	21
	(3) Ministerial regulation-making power	22
	(4) Conclusion	23
F	Other jurisdictions	23
	(1) England and Wales	23
	(2) Scotland	26
	(3) Northern Ireland	28
	(4) Australia	29
	(5) Canada	33
	(6) Conclusion	37
G	Conclusion	38
CHAPTER 2	STATUTORY REGULATIONS AND STANDARDS	39
A	Introduction	39
B	Regulations and Standards: Other Jurisdictions	39
	(1) England	40
	(2) Wales	50
	(3) Scotland	52
	(4) Northern Ireland	58
	(5) Conclusion	63

	C	Standards in Ireland for other sectors	65
		(1) Quality of life	66
		(2) Staffing	68
		(3) Protection	68
		(4) Health and development	69
		(5) Rights	71
		(6) Care environment	73
		(7) Governance and management	74
		(8) Conclusion	75
	D	Conclusion	75
CHAPTER 3		CARE CONTRACT	77
	A	Introduction	77
	B	Care contract and public standards	77
	C	Core provisions of the care contract	78
		(1) Competence of service provider	79
		(2) Provision of care	83
		(3) Protection	85
		(4) Medication management	88
		(5) Complaints procedures	91
		(6) Conclusion	93
	D	Conclusion	94
CHAPTER 4		CONTRACTING ARRANGEMENTS	95
	A	Introduction	95
	B	Contracting arrangements: who is the employer of the service provider?	95
	C	Contractual transparency	98
		(1) Contracting parties	98
		(2) Financial arrangements	107
	D	Some specific employment law responsibilities	109
		(1) General responsibilities under employment law	109
		(2) Safety and health responsibilities	111
	E	Mental capacity and domiciliary care	114
		(1) General authority to act on another's behalf	114
		(2) Personal guardian	115
		(3) Enduring power of attorney	116
		(4) Conclusion	116
CHAPTER 5		PROTECTIVE MEASURES	117
	A	Introduction	117
	B	Current screening and vetting arrangements for sensitive posts	117

	(1) “Soft” information	120
	(2) Abuse of vulnerable adults and elder abuse	121
C	Whistle-blowing protection and protected disclosures	124
	(1) Protection for Persons Reporting Child Abuse Act 1998	124
	(2) Protected disclosure in relation to the care of vulnerable adults	125
	(3) Other jurisdictions	128
D	Safeguards in other jurisdictions	129
	(1) England and Wales	129
	(2) Northern Ireland	133
	(3) Scotland	136
	(4) Australia	139
	(5) Alberta	141
	(6) British Columbia	143
E	Screening of domiciliary care professionals	145
	(1) Disclosure of information	145
	(2) Registration and certification	147
CHAPTER 6	SUMMARY OF PROVISIONAL RECOMMENDATIONS	149

TABLE OF LEGISLATION

Adult Guardianship Act 1996	RSBC 1996	BC
Aged Care Act 1997	1997, No.112	Aus
Canada Health Act 1984	1984, c.6	Can
Care Standards Act 2000	2000, c.14	Eng
Child Care Act 1991	1991, No.17	Irl
Community Care and Assisted Living Act 2003	2003, c.75	BC
Community Care and Assisted Living Act 2003	2003, c.75	BC
Constitution Act 1867	1867, c.3	Can
Data Protection (Amendment) Act 2003	2003, No. 6	Irl
Data Protection Act 1988	1988, No.25	Irl
Disability Act 2005	2005, No.14	Irl
Education for Persons with Special Educational Needs Act 2004	2004, No. 30	Irl
European Convention on Human Rights Act 2003	2003, No.20	Irl
Health (Corporate Bodies) Act 1961	1961, No.27	Irl
Health (Nursing Homes) Act 1990	1990, No.23	Irl
Health (Nursing Homes)(Amendment) Act 2007	2007, No.1	Irl
Health Act 1970	1970, No.1	Irl
Health Act 2004	2004, No.42	Irl
Health Act 2007	2007, No. 23	Irl
Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003	S.I. 2003 No. 431 (N.I.9)	NI
Health and Safety at Work Act 1974	1974	Eng and Wales
Health and Social Care (Community, Health and Standards) Act 2003	2003, c.43	Eng
Health and Social Care Professionals Act 2005	2005, No.27	Irl

Human Rights Act 1998	1998	UK
Interpretation Act 2005	2005, No.23	Irl
Mental Capacity Act 2005	2005, c.9	Eng
National Minimum Wage Act 2000	2000, No.5	Irl
Nursing Homes Support Scheme Act 2009	2009, No.15	Irl
Organisation and Working Time Act 1997	1997, No. 20	Irl
Payment of Wages Act 1991	1991, No.25	Irl
Police Act 1997	1997, c.50	Eng
Privacy Act 1988	1988, No.119	Aus
Protection for Persons Reporting Child Abuse Act 1998	1998, No.49	Irl
Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003	SI 2003 No.417 (NI4)	NI
Protection of Persons in Care Act 2000	2000, c. P-29	Alta
Protection of Persons in Care Act 2009	2009, c. P-29.1	Alta
Protection of Vulnerable Groups (Scotland) Act 2007	2007, asp.14	Scot
Regulation of Care (Scotland) Act 2001	2001, asp 8	Scot
Safeguarding Vulnerable Groups Act 2006	2006, c.47	Eng
Safety, Health and Welfare at Work Act 2005	2005, No. 10	Irl
Sale of Goods and Supply of Services Act 1980	1980, No.16	Irl
Social Welfare Consolidation Act 2005	No.26/2005	Irl
Taxes Consolidation Act 1997	1997, No. 39	Irl
Terms of Employment (Information) Act 1994	1994, No.5	Irl

TABLE OF CASES

Brooklyn House v Commission for Social Care Inspection	91 BMLR 22	Eng
Henry Denny & Sons Ltd v. Minister for Social Welfare	[1998] 1 IR 34	Irl
R (Wright) v. Secretary of State for Health	[2009] UKHL 3	UK
R. (A and B) v East Sussex County Council	[2003] EWHC 167 (Admin)	Eng

INTRODUCTION

A Background to the project

1. This Consultation Paper forms part of the Commission's *Third Programme of Law Reform 2008-2014*¹ and involves an examination of the extent to which the law should be reformed to ensure that appropriate legal standards are in place for professional carers, in particular those engaged in the provision of care to vulnerable persons in their home. The project follows on from previous work of the Commission in the area of vulnerable adults.

2. In its 2006 *Report on Vulnerable Adults and the Law*² the Commission recommended reform of the law on mental capacity as it affected vulnerable adults. The Commission recommended that legislation be enacted on mental capacity to include a presumption of capacity, and that specific arrangements be put in place to provide for the appointment of assisted decision-makers, to be called personal guardians, to maximise the autonomy of all adults, including those whose capacity might be impaired. The Commission's recommendations have been accepted by the Government, with the publication in 2008 of the *Scheme of a Mental Capacity Bill 2008*.³ The Commission's general approach in its 2006 Report, and reflected in the Government's 2008 Scheme, is to ensure that the law should provide all adults, including those who may be vulnerable, with the maximum degree of autonomy consistent with appropriate standards of protection.

B. The demographic and legal setting for this project

3. It is well known that the proportion of people living in Ireland who are aged over 65 has been increasing in recent years, and is projected to increase at an even greater rate over the next few decades. It is also well known, and entirely understandable, that the overwhelming majority of people aged over 65 wish to continue living in their own homes for as long as possible. Ideally, most people would prefer to continue to live, and ultimately to die, in their home rather than in a hospital, nursing home or other health care facility. As the

¹ Law Reform Commission, *Third Programme of Law Reform 2008-2014* (LRC 86-2007), Project 29.

² LRC 83-2006.

³ Available at www.justice.ie. The Government's April 2009 Legislation Programme indicates that a *Mental Capacity Bill* is to be published by the end of 2009.

Commission notes in detail in this Consultation Paper, the Government is committed to supporting this clear preference, most clearly indicated by the provision in recent years of home care support, primarily through the Department of Health and the Health Service Executive (HSE). At the same time, the home care provision by the State has been mirrored by the emergence of commercial home care providers.

4. In terms of regulation of the provision of care for older people, the Commission noted in its 2006 *Report on Vulnerable Adults and the Law*⁴ that considerable developments had occurred concerning the legal regulation of residential care in a nursing home setting. The Commission noted that, in 2006, the Government proposed to establish the Health Information and Quality Authority (HIQA) on a statutory basis. HIQA was established on a statutory basis by the *Health Act 2007*. The 2007 Act specifies that HIQA is the regulatory and standard-setting body for the residential nursing home setting. In this respect, in 2009 HIQA published national standards for the residential care setting.

5. The 2007 Act does not, however, empower HIQA to set comparable standards for the provision of health care in the home setting, sometimes referred to as the domiciliary care setting. The focus of this Consultation Paper is, therefore, to address the absence of legislative regulation of those providing professional care in the home, domiciliary, setting. As in the 2006 *Report on Vulnerable Adults and the Law*, the Commission's approach is predicated on maximising the autonomy of persons who interact with professional carers in the home setting, consistent with appropriate standards of protection.

C. Outline of this Consultation Paper

6. The Commission now proceeds to provide an overview of the Consultation Paper.

7. Chapter 1 provides an overview of the mechanisms currently in place to regulate providers who care for vulnerable adults. The absence of a statutory framework for regulating domiciliary care providers is highlighted, including the potential that this has to expose vulnerable persons to risk in their own homes. The potential role of the Health Information and Quality Authority (HIQA) and the Office of the Chief Inspector of Social Services (SSI) is also discussed in this context. The Commission then surveys the different approaches to regulation of domiciliary care providers in other States.

⁴ LRC 83-2006.

8. Chapter 2 examines in detail the legislation and associated standards that have been implemented in other States to regulate the provision of domiciliary care services. The standards published by HIQA in relation to the residential care sector are discussed for the purposes of identifying the key issues of importance. The National Quality Home Care Support Guidelines, which were drawn up by the HSE's Expert Advisory and Governance Group, are also discussed.

9. Chapter 3 examines the concept of a care contract. This is a type of agreement between the domiciliary care provider and the care recipient, which sets out the various policies and procedures which are necessary to protect vulnerable adults who receive domiciliary care services. Chapter 3 also examines the various issues which should form the core provisions of this care contract. The purpose of the care contract is to ensure that certain minimum requirements are satisfied by the domiciliary care provider in providing the service.

10. Chapter 4 examines the different types of contractual arrangements that can be entered into. The Commission discusses the distinction between a contract for services (engaging a contractor for a fee) and a contract of service (engaging an employee for a wage) in the context of domiciliary care. The different parties that may enter into a contract for the provision of care are identified, and the rights and responsibilities that attach as a result are discussed. The issue of a lack of mental capacity, as it relates to an individual's ability to enter into a contract for the provision of care, is also discussed.

11. In Chapter 5, the Commission discusses a number of protective measures to ensure high standards of selection are in place for professional carers and to maximise the protection of service recipients. The Commission discusses the proposed new offence of ill treatment or wilful neglect in the Government's *Scheme of a Mental Capacity Bill 2008*. The Commission then discusses how to protect those who disclose information about abuse or suspected abuse of a vulnerable adult. The chapter concludes with a discussion of arrangements for the screening and registration of professional domiciliary carers.

12. Chapter 6 contains a summary of the provisional recommendations in the Consultation Paper, as well as issues on which the Commission invites submissions.

13. This Consultation Paper is intended to form the basis for discussion and therefore all the recommendations made are provisional in nature. The

Commission will make its final recommendations on professional carers in the domiciliary setting following further consideration of the issues and consultation with interested parties. Submissions on the provisional recommendations included in this Consultation Paper are welcome. To enable the Commission to proceed with the preparation of its final Report, those who wish to do so are requested to make their submissions in writing by post to the Commission or by email to info@lawreform.ie by **30 November 2009**.

CHAPTER 1 REGULATION OF PROFESSIONAL HOME CARE PROVIDERS AND REFORM OPTIONS

A Introduction

1.01 This chapter describes the current arrangements for providing home care in Ireland. In Part B, the Commission outlines the demographic background against which home care arrangements are in place in Ireland. In Part C, the Commission describes the different delivery methods for home care packages currently available, both those made available by the State (primarily through the Department of Health and the Health Service Executive) and those available through private health care providers. Part D examines the regulation of residential care providers, as well as the impact of the *Health and Social Care Professionals Act 2005* on the regulation of other care professionals. The current legislation regulating home (domiciliary) care in Ireland is examined in Part E, which concludes that there is currently limited regulation in this area. In Part F, the Commission draws on the experience of models in other jurisdictions. In Part G, the Commission draws some conclusions and examines some general reform options.

B Professional Health Care at Home

1.02 Most people prefer to live in their own home rather than, for example, in a health facility such as a hospital or nursing home. The desire to live at home¹ may become even more important as people grow older. This was confirmed in a 2001 study by the National Council on Ageing and Older People (NCAOP), which found that a large majority of older people expressed the desire to continue to live in their own homes.² Since then, the Government has

¹ The concept of “home” is an important one. For the purposes of this project, a home is considered to be a dwelling, in which a person ordinarily resides in, which is not a hospital or a nursing home, but which can also include sheltered housing accommodation.

² Health and Social Services for Older People *The Years Ahead Report: A Review of the Implementation of its Recommendations*, National Council on Ageing and Older People, June 2001, at 23 ff.

adopted, as part of its national health policy, the principle that older people in particular should be enabled to be maintained in their home for as long as possible.

1.03 The 2006 Social Partnership Agreement *Towards 2016*³ commits the Government to enable “older people to maintain their health and well-being...in an independent way in their own homes and communities for as long as possible.” In order to achieve this objective, the Government and social partners are committed to ensuring that “every older person would have adequate support to enable them to remain living independently in their own homes for as long as possible.”

1.04 It is important to examine the general and demographic background against which the preference of older people to stay at home and the stated Government policy to support it should be considered. For the foreseeable future Ireland will have, in common with most European States, an ageing population. How – and where – they are cared for is an important policy matter. For older people with limited means, health care is provided by the State through its expenditure on health care from general taxation. For older people with greater income, health care may also be provided from their own funding arrangements, possibly supplemented by some State provision. The commitments in the 2006 Social Partnership Agreement *Towards 2016* indicate a clear Government policy in which health care provision in large purpose-built care settings, such as hospitals and nursing homes, is supplemented by – and possibly in some cases supplanted by – health care provision in the home setting. This policy not only supports the preferences of most people – including older people – but may also be motivated by cost factors: it is sometimes argued that care at home is less expensive than care in hospitals or nursing homes. These policy matters are, strictly speaking, outside the scope of this project. Whatever the policy debates, the Commission’s primary focus is on the legislative arrangements concerning health care in the private home setting.

1.05 In terms of the number of older people – those over 65 – that might be involved in health care provision at home, the 2006 National Census⁴ found that there were about 470,000 – 11% of the population - aged 65 years or over in the State. The Central Statistics Office (CSO) estimates that the number of people over 65 will almost double in every region of the State by 2026, with people aged 80 and over projected to more than double. The CSO projects that by 2026 there will be 909,000 older people – 25% of the total projected

³ *Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015* (Department of the Taoiseach, Government Publications, 2006) at Section 32: Older People.

⁴ See www.cso.ie.

population – living in the State.⁵ No doubt, many of these over 65s will be healthy and living at home – and also many of them will be working, whether part-time or full-time. On the other hand, a certain percentage of them will also require health care provision, whether in a hospital, nursing home or in their own home.

1.06 An ageing population is likely to bring a greater demand for health care provision in Ireland in the future. Combined with the wish of a large majority of older people to remain in their own homes, this clearly highlights, in the Commission’s view, the need to regulate the provision of health care providers in the home. At present, there is no clear legislative scheme for regulating what is sometimes called the domiciliary care sector, whether provided by the public sector or private sector. As later discussed, the care provided in the institutional setting of hospitals and nursing homes is subject to a clear legislative scheme under the standard-setting auspices of the Health Information and Quality Authority (HIQA), operating under the *Health Act 2007*. There are currently no comparable arrangements for the regulation of professional care providers in the home setting. Thus, service provision in this area is not regulated in the State.

1.07 By contrast, the domiciliary care sector is regulated in the United Kingdom. The Commission notes that some UK-based – and hence regulated – commercial providers have begun to provide such services in Ireland, whether as a HSE-approved service provider or by direct private contract with an Irish client or on behalf of HSE. To that extent, the UK standards have, in part, informed the informal standards on which some service provision occurs in Ireland. In the absence of a statutory framework, it is at least arguable that some service providers may not meet such standards⁶ and that, indeed, those who aspire to meet them may be at a competitive disadvantage by comparison with those who do not.

1.08 Where professional home care providers are not regulated, this may lead to inconsistencies in terms of service quality and delivery and the potential for abuse, including financial and physical abuse, as well as neglect. In 2008, the HSE dealt with over 1,800 cases of alleged abuse of older people, of which 85% occurred in the home.⁷ Of course, as already mentioned, most people

⁵ Central Statistics Office, “Regional Population Projections 2011-2026”, Table 3, 4th December 2008, www.cso.ie.

⁶ Ahern, Doyle and Timonen “Regulating Home Care of Older People: The Inevitable Poor Relation?” (2007) 29 *Dublin University Law Journal* 374 at 377.

⁷ “Reported cases of elder abuse top 1,800”, Irish Times report, 3rd February 2009, Barry Roche.

prefer to be at home and are not being abused at all times while at home. Nonetheless, where abuse occurs at home, there is a particular private aspect to its occurrence which makes abuse of a vulnerable adult difficult to detect and combat.⁸ In the United Kingdom, where the home care setting has been regulated, the Commission agrees with the views expressed by the English Department of Health that the regulation of domiciliary care providers is an effective method of augmenting standards and of providing the best protection for service recipients.⁹

1.09 It has been suggested that the regulation of the home care sector could have negative consequences for care workers, by restricting their ability to perform certain duties beyond their job description and might detract from the element of companionship that exists between care workers and care recipients.¹⁰ In the Commission's view, however, a balance must be struck between protecting vulnerable older persons and maintaining the unique relationship that can exist between the care worker and the service recipient. The regulation of care at home is an essential part of making sure that as many people as possible are supported and protected in their own home.

C Methods of Delivery of Professional Home Care

1.10 Professional home care is provided in many different forms and by many different care providers, public sector and private sector. It is important for this discussion to identify the different methods of delivery of professional home care, in particular for older people.

(1) HSE Home Help Services

1.11 Home help services are provided by the HSE in order to assist people to remain in their own home and to avoid the necessity of entering institutional care. It should be noted that home help services have no statutory basis. In practice, the HSE either provides the home help service directly or make arrangements with voluntary organisations to provide them. The service is generally free to medical card holders. Home helps usually assist people with normal household tasks although they may also help with personal care. In some cases, the service recipient may have to pay all of the costs involved. Where a person can afford to pay the costs of the home help service, then he or

⁸ Rickard-Clarke, "Elder Abuse – Legal Solutions" in O'Dell (ed) *Older People in Modern Ireland: Essays on Law and Social Policy* (FirstLaw, 2006) at 249.

⁹ For more information see Department of Health, "*Partial Regulatory Impact Analysis Domiciliary Care Standards*" (2001) available on www.dh.gov.uk.

¹⁰ Op cit fn6 at 393.

she can make an arrangement with the HSE in which the HSE is the employer and the service recipient pays the costs.

(2) HSE Home Care Support Scheme

1.12 The Home Care Support Scheme (also known as a *Home Care Support Package*) is a non-statutory scheme operated by the HSE. The scheme is aimed mainly at those requiring medium to high caring support to continue to live at home independently. This Scheme evolved from a range of pilot programmes but it is not currently (July 2009) a national scheme.¹¹ The Commission understands that national Guidelines for the Scheme are currently being developed. This would be a great advancement because, in their absence, the Commission understands that some HSE Local Health Offices (LHO) have drawn up local guidelines for implementation which differ from area to area. Some areas apply a means-test, others do not, and the means-tests that are enforced differ greatly. National guidelines would mean that the application of the Scheme does not depend on the place where a person happens to live.

1.13 Where a support package is provided, it is tailored to the needs of the individual. Broadly speaking, a package may include the services of nurses, home care attendants, home helps and the various therapies including physiotherapy services and occupational therapy services.¹² The packages vary according to the medical condition of the service recipient and the level of care required. Services may be provided by the HSE directly, or by voluntary and community organisations on behalf of the HSE. In some instances, a home care package will provide a cash grant to an individual or a member of his or her family in order to enable them to purchase a range of services or supports privately.¹³ Where this occurs there is a danger that the individual may be considered to be the employer of the care provider and as an employer; he or she will have certain duties and obligations.¹⁴

¹¹ For more information on the Home Care Support Scheme see www.dohc.ie in the Consumer Information section, under the Health Services for older people section.

¹² See the HSE website - http://www.hse.ie/eng/Find_a_Service/Older_People_Services/Benefits_and_Entitlements/Home_Care_Packages.html.

¹³ *Ibid.*

¹⁴ This contractual relationship shall be discussed in more detail in Chapter 3.

(3) Private commercial agencies

1.14 In recent years, home care packages have also been provided by commercial providers. This arises in two ways. In some instances, the HSE engages commercial providers to deliver the services under the Home Care Support Scheme already discussed, while in other instances an individual engages the commercial provider on a private contractual basis. As with the position where the HSE provides the home care directly, there is currently no legislative framework for the regulation of the service provision through these commercial providers.

1.15 In the absence of a legislative framework, the HSE engaged in a public national tender process for home care providers, with a view to drawing up a preferred provider list, which included a requirement that any successful tendering provider would meet certain stated standards. While the Commission acknowledges the value of this process, it remains the position that there is currently no external set of standards applicable to this method of home care service provision by which to determine whether the commercial providers meet these contractual standards.

1.16 Where an individual contracts directly with a commercial service provider, the Commission is aware that some contracts set out clearly the content of the particular service and the standards expected. The Commission notes, however, that in common with the other methods of service delivery, there is no statutory framework for this.

(4) Informal carers

1.17 There are approximately 160,000 informal carers in Ireland, often relatives and neighbours who provide more than 3 million hours of home-based care every week. It is estimated that, if this informal care was to be provided on a professional basis, the cost would amount to more than €2.5 billion every year.¹⁵ The State has recognised, to some extent, the important value of this care through the Carers' Grant, administered by the Department of Social and Family Affairs under the *Social Welfare Consolidation Act 2005*. The National Partnership Agreement *Towards 2016* contained a commitment to develop a National Carers' Strategy.¹⁶ The Strategy was to set out the Government's vision for family and informal carers and would have established a set of goals

¹⁵ "Carers group claims its members save State €2.5 billion", *The Irish Times*, Health Supplement, 10 February 2009.

¹⁶ *Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015* (Department of the Taoiseach, Government Publications, 2006) at 54.

and actions in relation to informal carers. In March 2009, the Minister for Social Welfare and Family Affairs stated that the Government was not proceeding with the publication of a National Carers' Strategy.¹⁷ As already noted, this project does not concern the informal carers with which the Strategy would be connected.

(5) Conclusion

1.18 It is important, in the context of this project, to have a clear understanding of the different types of home care that are available in Ireland. The provision of professional home care is complex and is provided in different forms by different providers. The provision of Home Care Support Packages represents a significant increase in funding for home care of older people. The emerging role of commercial domiciliary care providers presents some interesting issues, in terms of regulation and monitoring. This will be discussed later in this chapter. The role of informal carers is, strictly speaking, outside the scope of this project, but it is clear that the Home Care Support Schemes – and other community-based support schemes – often operate as a form of respite assistance for informal carers. To that extent, this project has an indirect connection to the role of informal carers.

D Regulation of other care professionals

1.19 There is a clear lack of regulation of the domiciliary care sector in Ireland but it is useful to examine the measures in place to regulate care provision in nursing homes. The *Health and Social Care Professionals Act 2005* is also discussed, in relation to how it regulates specific care professionals.

(1) Regulation of residential care providers

1.20 As already noted, there is currently no statutory framework for professional domiciliary care providers. The statutory regulation of health care provision in a nursing home setting has, however, undergone considerable change in recent years. The *Health (Nursing Homes) Act 1990* sets out the legislative framework for care standards in private nursing homes. The *Health Act 2007*, which established the Health Information and Quality Authority (HIQA), sets out a framework to set standards for both private residential care providers, including nursing homes, and also for the first time for public residential care providers including those provided through the HSE. HIQA is also the national inspection authority for all such residential care providers, public sector and private sector, the Commission now turns to provide an

¹⁷ Press Release "Government not proceeding with publication of a National Carers' Strategy" dated 3rd March 2009, available at www.welfare.ie.

overview of this legislative framework, which may provide a useful reference point for the future regulation of professional home care providers.

(a) Health (Nursing Homes) Act 1990

1.21 As mentioned the *Health (Nursing Homes) Act 1990*, as amended,¹⁸ sets out the legislative framework for monitoring standards in private nursing homes. Section 2(1) of the 1990 Act defines a “nursing home” as “an institution for the care and maintenance of more than two dependent persons.” The 1990 Act states that it does not extend to the regulation or inspection of public nursing homes,¹⁹ institutions for the care and maintenance of persons with limited mental capacity²⁰ or institutions in which children are maintained,²¹ but these are now covered by the *Health Act 2007*, discussed below. The 1990 Act also stated that maintenance provided by a person to a spouse or other relative was to be disregarded insofar as the definition of nursing home was concerned.²²

1.22 Under the 1990 Act, the HSE, as successor to the health boards, was the licensing and inspecting authority for private nursing homes.²³ The 1990 Act also empowered the HSE to set standards for private nursing homes. Under the *Health Act 2007*, discussed below, these functions have been transferred to HIQA.

¹⁸ The 1990 Act has been amended by the *Health (Nursing Homes) (Amendment) Act 2007* (primarily in the context of the State’s nursing home subvention arrangements) and by the *Health Act 2007* (primarily for the purposes of bringing private nursing homes under the remit of the standard-setting powers of HIQA).

¹⁹ Section 2(1)(a) of the 1990 Act.

²⁰ Section 2(1)(e).

²¹ Section 2(1)(f).

²² Proviso to section 6(1) of the 1990 Act. Section 6 will be repealed when the *Health Act 2007* comes into force fully. Section 104(1) of the 2007 Act, in accordance with Part 1 of Schedule 1, provides for the repeal of section 6 of the 1990 Act but this section has not yet (July 2009) come into effect. The definition of a “nursing home” in the 2007 Act clearly deals with facilities not provided by a private individual to a spouse or relative and it may have been considered unnecessary to repeat the proviso in section 6(1) of the 1990 Act.

²³ Section 6(2)(j) of the 1990 Act. Section 6 will be repealed when the *Health Act 2007* comes into force fully.

1.23 The *Nursing Homes (Care and Welfare) Regulations 1993*,²⁴ (the 1993 Regulations), made under section 6 of the *Health (Nursing Homes) Act 1990*,²⁵ set out specific requirements for the standards in the nursing home. These include requirements concerning: general welfare, high standards of nursing and medical care and privacy;²⁶ a contract of care;²⁷ staffing levels;²⁸ standards of accommodation and facilities;²⁹ hygiene and sanitary facilities;³⁰ nutrition;³¹ fire safety;³² a register of information and record keeping generally.³³ As they were made under the 1990 Act, the 1993 Regulations apply to private nursing homes only and do not extend to care provided in other settings.

1.24 The 1993 Regulations provided for inspection of private nursing homes by the HSE³⁴ and also set out a complaints procedure under which a dependent person being maintained in a nursing home may make a complaint to the HSE.³⁵ These functions have been transferred to HIQA under the *Health Act 2007*.

²⁴ S.I. No 226 of 1993, as amended by the *Nursing Homes (Care and Welfare) (Amendment) Regulations 1994*.

²⁵ The Regulation-making power in section 6 of the 1990 Act will be repealed when the *Health Act 2007* comes into force fully. Section 6 of the 1990 Act will be replaced by the Regulation-making power in section 101 of the 2007 Act. Pending the making of Regulations under 101 of the 2007 Act, the 1993 Regulations remain in force: see section 26 of the *Interpretation Act 2005*.

²⁶ Regulation 5 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

²⁷ Regulation 7 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

²⁸ Regulation 10 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

²⁹ Regulation 11(1) of the *Nursing Homes (Care and Welfare) Regulations 1993*.

³⁰ Regulations 14 and 15 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

³¹ Regulation 16(1) of the *Nursing Homes (Care and Welfare) Regulations 1993*.

³² Regulation 27 of the *Nursing Homes (Care and Welfare) Regulations 1993*, as amended by the *Nursing Homes (Care and Welfare) (Amendment) Regulations 1994*.

³³ Regulations 18 to 21 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

³⁴ Regulation 23 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

³⁵ Regulation 24 of the *Nursing Homes (Care and Welfare) Regulations 1993*.

1.25 While the 1993 Regulations set out some important statutory care standards, they did not, however, deal with the safety of dependent persons in nursing homes. Nor did they provide sufficient standards and procedures for preventing and investigating abuse. Following a TV documentary broadcast on RTE which indicated significant non-compliance with the standards in the 1993 Regulations at a registered nursing home, Leas Cross, the HSE commissioned a review of the matter. The subsequent 2006 report, *A review of the deaths at Leas-Cross Nursing Home 2002-2005* (O'Neill Report),³⁶ concluded that a lack of resources meant that inspections under the 1993 Regulations were not conducted frequently.³⁷ The Report also concluded that the practice of conducting inspections under the 1993 Regulations on the basis of prior notice was inappropriate. The findings in the Report contributed to the enactment of a comprehensive and independent inspection system in the *Health Act 2007*.

(b) The Health Act 2007 and HIQA

1.26 As indicated, the *Health Act 2007* established the Health Information and Quality Authority (HIQA)³⁸ as an independent inspectorate with responsibility for regulating and inspecting both public and private nursing homes. The main object of HIQA is to “promote safety and quality in the provision of health and personal social services for the benefit of the health and welfare of the public.”³⁹

1.27 HIQA is empowered by the 2007 Act to publish standards on safety and quality in relation to health care services provided by the HSE in institutional care settings and by private service providers in nursing homes. HIQA is also required to monitor compliance with these standards⁴⁰ and undertake an investigation as to the safety, quality and standards of the services if it believes on reasonable grounds that there has been a serious risk to the health or welfare of a person receiving those services.⁴¹

³⁶ O'Neill, *A review of the deaths at Leas-Cross Nursing Home 2002-2005* (HSE, 2006). In July 2009, the Report of a Commission of Investigation into Leas Cross (conducted by Diarmuid O'Donovan SC), available at www.dohc.ie reached similar conclusions.

³⁷ *Ibid*, p.3.

³⁸ Section 6 of the *Health Act 2007*.

³⁹ Section 7 of the *Health Act 2007*.

⁴⁰ Section 8(1)(c) of the *Health Act 2007*.

⁴¹ Section 9(1)(a) of the *Health Act 2007*.

1.28 Using these standard-setting powers, HIQA has published a number of standards on safety and quality in relation to health care services generally.⁴² In the context of the scope of the Commission's focus on professional health care at home, HIQA has published *Standards for Residential Care Settings for Older People* (2007)⁴³ and *National Quality Standards: Residential Services for People with Disabilities* (2009).⁴⁴

(2) Health and Social Care Professionals Act 2005

1.29 The Health and Social Care Professionals Council (the Council) was established by the *Health and Social Care Professionals Act 2005*⁴⁵ to promote high standards of professional conduct and professional education, training and competence among registrants of designated professionals. The Council's functions include the monitoring and co-ordination of the activities of registration boards, the enforcement of standards of practice for registrants of the designated professions, the establishment of committees of inquiry into complaints and the making of decisions and the giving of directions relating to the imposition of disciplinary sanctions on registrants of the designated professions.⁴⁶ The designated professions are clinical biochemists; dieticians; medical scientists; occupational therapists; orthoptists; physiotherapists; podiatrists; psychologists; radiographers; social care workers; social workers and speech and language therapists.⁴⁷

1.30 A "health or social care profession" is defined in the 2005 Act as any profession in which a person exercises skill or judgment relating to the preservation or improvement of the health or wellbeing of others; the diagnosis, treatment or care of those who are injured, sick, disabled or infirm or the care of those in need of protection, guidance or support.⁴⁸ Under the 2005 Act, the Minister for Health and Children has the authority to designate any health or

⁴² These include: *Hygiene Standards* (2008), *Standards for Infection Prevention and Control* (2008) and *Symptomatic Breast Disease Standards* (2006: published when HIQA had been established on an interim basis, prior to the 2007 Act).

⁴³ Health Information and Quality Authority *Standards for Residential Care Settings for Older People* available at www.hiqa.ie.

⁴⁴ Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* available at www.hiqa.ie.

⁴⁵ Section 6(1) of the *Health and Social Care Professionals Act 2005*.

⁴⁶ Section 8 of the *Health and Social Care Professionals Act 2005*.

⁴⁷ Section 4 of the *Health and Social Care Professionals Act 2005*.

⁴⁸ Section 4(3) of the *Health and Social Care Professionals Act 2005*.

social care profession not explicitly included under the Act.⁴⁹ Where the Minister considers that it is appropriate and in the public interest for a health or social care profession to be designated under the 2005 Act, the Minister must have regard to the extent to which the profession has a defined scope of practice, the extent to which the profession is established, and whether there is a professional representative body to represent a significant proportion of the profession's practitioners.⁵⁰ The Minister must also take into consideration the extent to which there are defined routes of entry to the profession, whether the entry qualifications are independently assessed and whether the profession is committed to continuing professional development.⁵¹ The Minister must finally consider the degree of risk to the health, safety and welfare of the public from an incompetent, unethical or impaired practice of the profession.⁵²

1.31 The 2005 Act establishes registration boards for designated professions for the purpose of establishing and maintaining a register of members,⁵³ to give guidance to registrants concerning ethical conduct and to monitor the continuing suitability of programmes approved by the board for the education and training of applicants for registration.⁵⁴ All registrants must comply with the conditions of application, and must hold an approved qualification in the relative profession. The registrant must be a fit and proper person and must pay the required fee to the Council.⁵⁵

1.32 As stated previously, one of the main functions of the Council is to make decisions and give directions relating to imposing disciplinary sanctions on registrants of the designated professions.⁵⁶ The Council must establish a

⁴⁹ Section 4(2) of the *Health and Social Care Professionals Act 2005* provides that a profession may come under this provision provided it is not already regulated under an Act of the Oireachtas, and interested parties are given an opportunity to make representations, and the Minister considers it appropriate and in the public interest that the profession be designated under the Act.

⁵⁰ Section 4(4) of the *Health and Social Care Professionals Act 2005*.

⁵¹ Section 4(4)(c)-(d) of the *Health and Social Care Professionals Act 2005*.

⁵² Section 4(4)(e) of the *Health and Social Care Professionals Act 2005*. The Minister may also take into consideration any other factor he or she believes is relevant.

⁵³ See also section 36 of the *Health and Social Care Professionals Act 2005*.

⁵⁴ Section 27(3) of the *Health and Social Care Professionals Act 2005*.

⁵⁵ Section 38 of the *Health and Social Care Professionals Act 2005*.

⁵⁶ See Part 6 of the *Health and Social Care Professionals Act 2005*.

preliminary proceedings committee, a professional conduct committee and a health committee.⁵⁷ Under the 2005 Act, a complaint may be made about a registrant to the Council on grounds of professional misconduct; poor professional performance; impairment of the registrant's ability to practise; failure to comply with a term or condition of registration.⁵⁸ Once the Council receives a complaint, it must then refer the complaint to a preliminary proceedings committee for its opinion as to whether further action is required.⁵⁹ Where the committee decides that further action is required to deal with the complaint, then it may refer the complaint to either a professional conduct committee or a health committee.⁶⁰

1.33 Once a committee of inquiry has completed its assessment, it must then report its findings to the Council,⁶¹ which can then either dismiss the complaint or request the registration board to recommend disciplinary sanctions.⁶² The registration board can recommend a variety of sanctions including an admonishment or censure; conditions to be attached to the registration; the suspension of registration for a specified time; the cancellation of registration; or a prohibition from applying for a specified period for restoration to the register.⁶³ Where a disciplinary sanction is imposed upon a registrant, that person may apply to the Court for an order cancelling the direction.⁶⁴ The Court, upon hearing the application, may cancel, confirm or modify the decision and may direct the Council accordingly. Upon the application of an individual whose registration has been cancelled, the Council may at any time direct a registration board to restore to its register the name of any person whose registration has been cancelled provided that certain conditions are satisfied.⁶⁵ Where the Council does not approve of the

⁵⁷ Section 51 of the *Health and Social Care Professionals Act 2005*.

⁵⁸ Section 52 of the *Health and Social Care Professionals Act 2005*.

⁵⁹ Section 53 of the *Health and Social Care Professionals Act 2005*.

⁶⁰ Section 56(1) of the *Health and Social Care Professionals Act 2005*. A hearing before a professional conduct committee must in general be held in public, whereas a hearing before a health committee shall in general, not be held in public, see section 58 of the *Health and Social Care Professionals Act 2005*.

⁶¹ Section 63 of the *Health and Social Care Professionals Act 2005*.

⁶² Section 64 of the *Health and Social Care Professionals Act 2005*.

⁶³ Section 65 of the *Health and Social Care Professionals Act 2005*.

⁶⁴ Section 69 of the *Health and Social Care Professionals Act 2005*.

⁶⁵ Section 73(2) of the *Health and Social Care Professionals Act 2005*.

application, the individual concerned can appeal the decision to the High Court, which can then cancel, confirm or modify the decision and direct the Council.⁶⁶

(3) Conclusion

1.34 There have been some significant legislative developments in recent years in the regulation of professionals that operate in the care sector. In particular, there have been major changes in the regulation of residential care providers, with HIQA beginning to carry out inspections on all residential care providers. The *Health and Social Care Professionals Act 2005* also represents a significant milestone in the registration and inspecting of specified professions. Although the Minister for Health and Children has the authority to designate a health or social care profession under the 2005 Act, it would appear that domiciliary care providers do not satisfy certain conditions that the Minister must take into account prior to designating a profession under section 4 of the 2005 Act. Therefore, domiciliary care providers would, in the Commission's view, be better regulated by some other means.

E Regulation of domiciliary care providers

1.35 The government has a clear policy on the care of older people which favours the provision of care in domiciliary settings as opposed to institutional settings. This policy, first advocated in the 1988 Report *The Years Ahead*,⁶⁷ favours maintaining older people in dignity and independence at home in accordance with their wishes until they can no longer be so maintained. The 1988 report contained a broad range of diverse recommendations aimed at improving the quality of care being provided to older people. It also made numerous specific recommendations with regard to the provision of general medical, nursing and paramedical services to home based services. The main aim of these recommendations was to strengthen the provision of care at home. The report recommended that the then health boards (now the HSE) should explore the possibility of employing care assistants who would work under the supervision of the public health nurse,⁶⁸ though it did not specify what duties these assistants would have or what specific training they should have. The report also recommended that where necessary physiotherapy, speech therapy and chiropody should be provided to those receiving care at home.⁶⁹

⁶⁶ Section 75(4) of the *Health and Social Care Professionals Act 2005*.

⁶⁷ National Council for the Elderly, "*The Years Ahead*", 1988.

⁶⁸ Recommendation 6.29 of the 1988 Report.

⁶⁹ Recommendation 6.37 of the 1988 Report.

(1) Function of HIQA

1.36 Despite this very clear policy on older care, there is no legislation or service provision to give effect to it. As discussed above, HIQA is now empowered to regulate all residential care providers under the *Health Act 2007*. HIQA does not, however, have statutory authority to set standards on safety and quality in relation to providers of health care services in private homes. While the *Health Act 2007* has ensured greater regulation of institutional care through the activities of HIQA, there is still a poor level of regulation of those who provide domiciliary care to vulnerable people.

1.37 It has been suggested⁷⁰ that putting in place a regulatory system for institutional care while ignoring the domiciliary care system is counter-productive, and contradicts the Government's intentions to regulate both sectors.⁷¹ Abuse of vulnerable persons who receive domiciliary care is one of the most common forms of abuse, but it presents the most difficulties in terms of prevention and detection.⁷² The risk of not regulating the domiciliary care sector poses many qualitative and safety issues, including inconsistency in terms of the quality and reliability of the service.⁷³ The absence of statutory regulation also gives rise to safety concerns regarding the suitability of staff and management, and the vulnerability to abuse of care recipients. The absence of regulation also raises concerns over inadequate provisions to ensure safety, security, wellbeing and confidentiality for domiciliary care recipients.⁷⁴

1.38 A person who, by reason of illness, infirmity or disability is unable to provide personal care for themselves and receives this care from a formal or paid carer in their own home, is said to be receiving domiciliary care. Under section 61 of the *Health Act 1970*, the HSE *may* make arrangements to assist (with or without charge) in the maintenance at home of:

- (a) a sick or infirm person or a dependent of such a person or

⁷⁰ Ahern, Doyle and Timonen "Regulating Home Care of Older People: The Inevitable Poor Relation?" (2007) 29 *Dublin University Law Journal* 374 at 395.

⁷¹ *Ibid.*

⁷² Rickard-Clarke, "Elder Abuse – Legal Solutions" in O'Dell (ed) *Older People in Modern Ireland: Essays on Law and Policy*, (First Law, 2006) at 265.

⁷³ *Op. cit.*, fn70 at 378.

⁷⁴ *Ibid.*

(c) a person who, but for the provision of a service for him under this section would require him to be maintained otherwise than at home.⁷⁵

1.39 Section 61A(1) of the *Health Act 1970* (inserted by section 11 of the *Health (Nursing Homes)(Amendment) Act 2007*) requires home care providers to give notice in writing to the HSE of the name and address of the home care provider, and also the name and address of each care recipient.⁷⁶ Under section 61A(2) of the 1970 Act, the HSE is permitted to retain this information and may publicly disclose any particulars of home care providers who are legal persons or any statistics from such information. A home care provider is defined as “a natural or legal person who...provides at a charge, home care services.” A “home care service” is defined as “...a service made available in a private dwelling for a person who, by reason of illness, frailty or disability, is unable to provide the service for himself or herself without assistance.”⁷⁷

1.40 Section 8(1)(b) of the *Health Act 2007*, under which HIQA was established, describes the functions of HIQA and states that one of its functions is to set standards for “services provided by the [HSE] or a service provider” who provides health and personal social services on behalf of the HSE. A “service provider” means someone who “enters into an arrangement...to provide a health or personal social service on behalf of the [HSE].”

1.41 It has been suggested⁷⁸ that section 8(1)(b) could be interpreted as permitting HIQA to lay down quality standards in respect of domiciliary care if it can be interpreted as “personal care” or as a “personal social service” being provided by a service provider on behalf of the HSE. However, where the HSE finances the provision of home care by a private agency to an individual, it is not clear whether HIQA would have authority to regulate or monitor such a body.⁷⁹ Currently, therefore, there is no clear legislative provision which expressly states that HIQA has authority to set standards for, and carry out inspections of domiciliary care providers. The Commission has come to the conclusion that the legislative gap should be filled and provisionally recommends, therefore, section 8(1)(b) of the *Health Act 2007* be amended to extend the authority of the Health

⁷⁵ Section 61(1) of the *Health Act 1970*.

⁷⁶ *Ibid* at section 61A(1).

⁷⁷ See section 61A(3) of the *Health Act 1970*.

⁷⁸ Ahern, Doyle and Timonen “Regulating Home Care of Older People: The Inevitable Poor Relation?” (2007) 29 *Dublin University Law Journal* 374 at 381.

⁷⁹ This issue shall be discussed in more detail in Chapter 3.

Information and Quality Authority to include the regulating and monitoring of professional domiciliary care providers.

1.42 *The Commission provisionally recommends that section 8(1)(b) of the Health Act 2007 be amended to extend the authority of the Health Information and Quality Authority to include the regulating and monitoring of professional domiciliary care providers.*

(2) Role of the Office of the Chief Inspector of Social Services

1.43 Section 40 of the *Health Act 2007* established the Office of the Chief Inspector of Social Services (the Social Services Inspectorate “SSI”). Section 41 sets out the specific statutory functions of the Chief Inspector. The function of SSI is to register and inspect the residential care services provided by designated centres. A “designated centre” is defined as including a residential service in the public, private and voluntary sector for older people and people with a disability.⁸⁰ The SSI must establish and maintain a register of all designated centres, and must regularly inspect them to assess whether they are complying with the any regulations and/or standards that are set down.⁸¹

1.44 Under the 2007 Act, a person seeking to register or renew a registration of a designated centre must apply to the SSI to register for a three year period.⁸² The SSI must establish and maintain a list of all registered designated centres. The SSI may grant registration to the registered provider, provided that he or she is a fit person, and provided that the centre is operated in a manner that complies with any regulations and standards.⁸³ Where an application is granted or the renewal of registration is approved, the SSI must issue a certificate of registration to the registered provider of the designated centre.⁸⁴ Registration of a designated centre can be cancelled if the registered provider is convicted of a particular offence as prescribed by the 2007 Act, or the SSI is of the opinion that the registered provider is no longer fit or the designated centre is not being appropriately managed.⁸⁵ Where the SSI proposes to refuse to grant an application, the registered provider must be notified in writing of the proposal, and must be afforded the opportunity to

⁸⁰ Section 2 of the *Health Act 2007*.

⁸¹ Section 41(1)(b) of the *Health Act 2007*.

⁸² See section 48 and section 49(2) of the *Health Act 2007*.

⁸³ Section 50 of the *Health Act 2007*.

⁸⁴ Section 50(3) of the *Health Act 2007*.

⁸⁵ Section 51 of the *Health Act 2007*.

respond in writing to the proposed refusal.⁸⁶ The SSI must then take any written submissions made by the registered provider into account, before making its final decision. Once a final decision has been made, the registered provider or the applicant can appeal the SSI decision to the District Court within 28 days of receipt of the written notice of the decision.⁸⁷ The District Court may then either confirm the SSI decision or may instruct SSI to register the designated centre or to restore the registration or make an order as to conditions attaching to registration.⁸⁸ The decision can further be appealed to the Circuit Court.⁸⁹

1.45 Amending the definition of “designated centre” to include domiciliary care providers would ensure that all professional domiciliary care providers are required to apply to SSI to become registered care providers. The SSI could then inspect the services being provided by the domiciliary care providers, thereby monitoring their compliance with any Ministerial Regulations and any standards set out by HIQA. This would also ensure that all registered domiciliary care providers would be certified. The *Health Act 2007* protects all registered providers, by ensuring that they have a right to respond to a decision of SSI and by ensuring that there is recourse to the courts. The Commission is of the opinion that the SSI as established by the 2007 Act provides an appropriate mechanism by which domiciliary care providers can be registered and inspected.

1.46 *The Commission provisionally recommends the amendment of the definition of a “designated centre” in section 2(1) of the Health Act 2007 to include domiciliary care providers. This would extend the power of the Office of the Chief Inspector of Social Services under section 41 of the Health Act 2007 to register and monitor professional domiciliary care providers.*

(3) Ministerial regulation-making power

1.47 Under section 101 of the *Health Act 2007*, the Minister for Health and Children may make Regulations for the purpose of ensuring proper standards in relation to designated centres. Such Regulations may refer to the maintenance, care, welfare and well-being of persons resident in a designated centre as well as other regulations to govern specific aspects of the operation of designated centres. In keeping with the provisional recommendations already made in connection with the extension of the 2007 Act to include domiciliary care, the Commission provisionally recommends extending the Ministerial regulation-

⁸⁶ Section 53 of the *Health Act 2007*.

⁸⁷ Section 57 of the *Health Act 2007*.

⁸⁸ Section 57(4)(a) of the *Health Act 2007*.

⁸⁹ Section 62 of the *Health Act 2007*.

making power conferred in the Minister for Health and Children by section 101 of the *Health Act 2007*, to include the authority to make Regulations in respect of professional domiciliary care providers..

1.48 *The Commission provisionally recommends extending the Ministerial regulation-making power conferred on the Minister for Health and Children by section 101 of the Health Act 2007 to include the authority to make Regulations in respect of professional domiciliary care providers.*

(4) Conclusion

1.49 This Part has examined how the legislation currently in place to regulate residential care providers could be amended to incorporate the regulation of domiciliary care providers. The *Health Act 2007* provides a comprehensive statutory framework through which the residential care sector is regulated. HIQA has already been active in its role of setting standards for the care sector, and although the SSI has only recently begun to carry out its role of inspecting residential care providers to ensure they are complying with HIQA's standards, it is clear that standards within the residential care sector will be considerably augmented. The *Health Act 2007* already provides a comprehensive statutory framework through which the residential care sector is regulated, and it would be practical to extend the ambit of the 2007 Act to include the regulation of domiciliary care providers as already discussed above. This would ensure that there is an established body charged with the responsibility of: registering domiciliary care providers; setting standards for those providers; and monitoring those providers compliance with those standards.

F Other jurisdictions

1.50 In England and Wales, the *Care Standards Act 2000* was introduced creating a detailed system of regulation, registration and inspection for domiciliary care providers. Similar legislative measures have been adopted in Scotland and Northern Ireland. While there is a considerable amount of legislation relating to the care of older people in Australia, the regulatory system for health care providers is complex, and differs greatly depending on the type of care concerned.

(1) England and Wales

1.51 By comparison with the incomplete legislative position in Ireland, the law regarding the regulation of domiciliary care providers in England and Wales is comprehensive. The *Care Standards Act 2000* is a wide-ranging piece of legislation, which regulates a broad range of health care providers, including domiciliary care agencies, and care homes, amongst others. A "domiciliary care provider" is defined under the 2000 Act as

“. . . an undertaking which consists of or includes arranging the provision of personal care in their own homes for persons who by reason of illness, infirmity or disability are unable to provide it for themselves without assistance.”⁹⁰

The 2000 Act established the National Care Standards Commission (NCSC). The NCSC was an independent, non-governmental body, responsible for the registration, regulation and inspection of a long list of health care providers. Its regulatory powers have now been subsumed into the Commission for Social Care Inspection (CSCI).⁹¹ The CSCI has been renamed the Care Quality Commission (CQC).

1.52 The CQC has the responsibility for regulating health care providers, by requiring care providers to register with it,⁹² and by conducting regular inspections of such health care providers.⁹³ The 2000 Act also provides that the relevant Minister may make Regulations in order to secure the welfare of persons provided with services by a domiciliary care agency.⁹⁴ Regulations made in such a way may make provision as to the promotion and protection of the health of persons receiving domiciliary care.⁹⁵ Under the 2000 Act the relevant Minister may prepare and publish statements of “National Minimum Standards” which can apply to domiciliary care agencies.⁹⁶

1.53 The CQC registers, inspects and reviews all adult social care services in the public, private and voluntary sectors in England. The registration process ascertains that the people who own or manage a service are suitable and that the service will be operated in accordance with all regulations and Government standards.⁹⁷ Where someone is seeking to register a service, the

⁹⁰ As per section 4(3) of the *Care Standards Act 2000*.

⁹¹ Section 102(3) *Health and Social Care (Community, Health and Standards) Act 2003* transferred the functions of the National Care Standards Commission under Part II of the *Care Standards Act 2000* to the Commission for Social Care Inspection in April 2004.

⁹² Section 11(1) of the *Care Standards Act 2000*.

⁹³ Section 31 of the *Care Standards Act 2000*.

⁹⁴ As per section 22(2)(d) of the *Care Standards Act 2000*.

⁹⁵ As per section 22(5) of the *Care Standards Act 2000*.

⁹⁶ Section 23 of the *Care Standards Act 2000*. The National Minimum Standards: Domiciliary Care will be discussed in more detail in Chapter 2.

⁹⁷ See www.cqc.org.uk for more information regarding the particulars of the registration and inspection process.

CQC must be furnished with information relating to the staff and the service facilities.⁹⁸ The CQC inspects adult social care services against national minimum care standards.⁹⁹ There are three types of inspections that the CQC carry out (i) key inspections; (ii) random inspections and (iii) and thematic inspections. Key inspections are conducted on an unannounced basis, and they assess how the service is performing in accordance with the care standards. This inspection also involves the service recipients and the service operators. The random inspections are targeted inspections that focus on specific issues, or check-up on the service to determine if it is operating in accordance with the standards. Random inspections are also unannounced and can take place at any time of the day or night. Finally, thematic inspections focus on how well a service is performing in a particular area of its service provision. For example, a thematic inspection might focus on the maintenance of medical records or the protection of the service recipient's rights and dignity. Once an inspection has been carried out, a report is published, and issued to the owner of the service, who then has 28 days in which to comment on the report, before it is published on the CQC website. The service owner is given ample opportunity to rectify any problems which arise out of the inspection report. If a service provider continuously fails to meet the standards enforced by the CQC, then he or she can be found guilty of an offence¹⁰⁰ and the CQC can close the service down.

1.54 The 2000 Act also applies to Wales. Under the 2000 Act the Care and Social Services Inspectorate Wales (CSSIW) was established in April 2007 as an independent regulator of the public and private sector care providers. The CSSIW is a distinct division within the Welsh Department of Public Services and Performance. Like the CQC in England, the CSSIW seeks to safeguard and promote the health and well-being of service users in Wales. The CSSIW seeks to ensure that common standards are applied in a consistent manner across the care sector, to public and private sector care providers by an independent regulator.¹⁰¹ The functions and powers of the CSSIW are the same as those of the CQC as already set out above. The CSSIW inspects and reviews local authority social services and regulates and inspect care settings and agencies, including adult care homes and domiciliary care agencies, amongst others. The

⁹⁸ See Schedule II of the *National Care Standards Commission (Registration) Regulations 2001* for further details.

⁹⁹ Section 31 of the *Care Standards Act 2000*.

¹⁰⁰ Section 24 of the *Care Standards Act 2000*.

¹⁰¹ For more information see www.cssiw.org.uk.

Welsh Assembly has published regulations in relation to domiciliary care agencies, which will be discussed in Chapter 2.¹⁰²

(2) Scotland

1.55 In Scotland, the *Regulation of Care (Scotland) Act 2001* established the Care Commission as a corporate body, which has the general duty of furthering improvement in the quality of care services provided in Scotland.¹⁰³ The Care Commission is responsible for registering and inspecting various different health care providers, including care homes, support services and adult placement services.¹⁰⁴ The 2001 Act aims to enhance the safety and welfare of all persons who use, or are eligible to use, care services and to promote the independence of those persons.¹⁰⁵

1.56 The term “care services” is defined as including “care homes” and “support service” amongst a broad variety of other care services.¹⁰⁶ The term “support services” is defined by section 2(2) of the 2001 Act as:

“...a service provided, by reason of a person’s vulnerability or need, to that person. . . by

- (a) a local authority,
- (b) any person under arrangements made by a local authority,
- (c) a health body or
- (d) any person if it includes personal care or personal support.”

A “support service” does not include care homes, but it does include a private or voluntary service providing personal care under direct arrangements with a vulnerable adult.¹⁰⁷

1.57 Under the 2001 Act, the Scottish Ministers have the authority to draw up regulations which may make provision for securing the welfare of persons

¹⁰² *Domiciliary Care Agencies (Wales) Regulations 2004*, Welsh Statutory Instruments 2004 No. 219 (W23).

¹⁰³ Section 1(1) *Regulation of Care (Scotland) Act 2001*.

¹⁰⁴ See the *Regulation of Care (Scotland) Act 2001*, and the Care Commission’s website www.carecommission.com.

¹⁰⁵ Section 59 of the *Regulation of Care (Scotland) Act 2001*.

¹⁰⁶ Section 2(1)(a)-(b) of the *Regulation of Care (Scotland) Act 2001*.

¹⁰⁷ See www.scotland.gov.uk under the Health and Community Care section for more detail.

provided with a care service.¹⁰⁸ The Act also confers on the Care Commission the function of registering and regulating of care services. The Scottish Ministers set up the National Care Standards Committee,¹⁰⁹ which developed the National Care Standards, which will be discussed further in Chapter 2.¹¹⁰ The Care Commission considers these national care standards when inspecting care providers.¹¹¹ The 2001 Act also establishes the Scottish Social Services Council which registers, regulates and trains social service workers.¹¹²

1.58 The requirements and processes for registration and inspection as prescribed under the 2001 Act, mirrors those set out under the English *Care Standards Act 2000*. The same requirements that are set down by the English *Care Standards Act 2000* for the registration of a care service, apply to the registration of a care service in Scotland. Any person who seeks to provide a care service is required to make an application to register with the Care Commission.¹¹³ It is an offence to provide a care service without being registered with the Care Commission.¹¹⁴ The Care Commission is also charged with inspecting care service providers.¹¹⁵ The Care Commission can authorise a person to inspect any care service and enter and inspect the care premises at any time day or night.¹¹⁶ Under the 2001 Act, care homes must be inspected at least twice a year, while “support services” must be inspected at least once a year.¹¹⁷ After a care service is inspected, the Care Commission must publish its

¹⁰⁸ Section 29(2)(e) of the *Regulation of Care (Scotland) Act 2001*.

¹⁰⁹ Initially, the Scottish Ministers established a body named the National Care Standards Committee, which had responsibility for publishing and reviewing national standards for care services. This body was renamed the Care Standards and Sponsorship Branch. For more information about the Care Standards and Sponsorship Branch see the Care Standards and Sponsorship Branch section on www.scotland.gov.uk/Topics/Health/care.

¹¹⁰ Section 5 of the *Regulation of Care (Scotland) Act 2001*.

¹¹¹ For more information see www.scotland.gov.uk under the Health and Community Care section.

¹¹² See Part 3 of the *Regulation of Care (Scotland) Act 2001* for more details about the Scottish Social Services Council.

¹¹³ Section 7 of the *Regulation of Care (Scotland) Act 2001*.

¹¹⁴ Section 21(1) of the *Regulation of Care (Scotland) Act 2001*.

¹¹⁵ Section 25(2) of the *Regulation of Care (Scotland) Act 2001*.

¹¹⁶ Section 25(2)(a)-(b) of the *Regulation of Care (Scotland) Act 2001*.

¹¹⁷ Section 25(3) and section 25(5) of the *Regulation of Care (Scotland) Act 2001*.

inspection report, giving the owner/manager of the service an opportunity to comment on the report.¹¹⁸

(3) Northern Ireland

1.59 The Northern Ireland Health and Personal Social Services Regulation and Improvement Authority was established by section 3 of the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*.¹¹⁹ The Regulation and Improvement Authority is an independent body, charged with the responsibility of regulating establishments and agencies within the statutory and independent health care sectors. The role of the Regulation and Improvement Authority is to monitor and improve the quality of the health and personal social services, by conducting reviews of the statutory bodies.¹²⁰ The Authority also has the function of carrying out inspections of statutory bodies and service providers, and persons who provide or are to provide services for which such bodies or providers have responsibility.¹²¹

1.60 The Northern Ireland Department of Health, Social Services and Public Safety is empowered to publish minimum standards which the Regulation and Improvement Authority must then consider when regulating establishments and agencies.¹²² The Authority has the responsibility of regulating a wide range of establishments and agencies, including nursing homes, residential care homes, domiciliary care agencies, as well as children's homes, independent clinics and hospitals.¹²³ This unified approach to regulation and monitoring is advantageous as it ensures consistency across the board in terms of regulation and inspection of all health care providers, regardless of whether they are statutory bodies or independent agencies.

¹¹⁸ Section 27(5) of the *Regulation of Care (Scotland) Act 2001*.

¹¹⁹ *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*, (HPSS NI Order).

¹²⁰ Article 35(1)(a) of the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*.

¹²¹ Article 35(1)(d) of the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*.

¹²² Article 38 of the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*.

¹²³ Article 8 of the *Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003*.

(4) Australia

1.61 The Australian Government has a policy of promoting and funding the care of older people, by providing a wide variety of care packages. The Government provide for both residential aged care and home and community care packages. Residential aged care includes publicly-funded places in aged care homes. These places are allocated to older people who are unable to care for themselves. There is also an extensive programme of community care packages provided to cater for those older people who wish to remain in their own homes. There is no unified approach to the regulation of the health care sector in Australia. No one body is charged with the responsibility of monitoring and assessing community care providers.

1.62 The Australian Government introduced the *Aged Care Act 1997*. While the main focus of this Act is the funding of aged care services,¹²⁴ it also seeks to promote a high quality of care for the recipients of aged care services¹²⁵ and to protect the health and well-being of the recipients of aged care services.¹²⁶ Under the *Aged Care Act 1997*, the term “aged care” includes residential care, community care and flexible care.¹²⁷

1.63 While the 1997 Act has several objectives, the main purpose of the Act is to provide for the Commonwealth to give financial support for the provision of aged care through the payment of subsidies and grants.¹²⁸ Eligibility for a subsidy depends on whether the care provider has been approved i.e. whether it meets the accreditation requirement. Once a provider has been approved, it incurs certain responsibilities which relate to the quality of care provided, the rights of the care recipients and accountability for the care provided.

(a) Regulation of Residential Care Providers in Australia

1.64 Aged care in Australia is a complex and, at best, loosely coordinated web of Commonwealth and State-funded and regulated services delivered by both not-for-profit and commercial enterprises.¹²⁹ Providers of residential care

¹²⁴ Section 2-1(1)(a) of the *Aged Care Act 1997*.

¹²⁵ Section 2-1(1)(b) of the *Aged Care Act 1997*.

¹²⁶ Section 2-1(1)(c) of the *Aged Care Act 1997*.

¹²⁷ As per Schedule 1 of *Aged Care Act 1997*.

¹²⁸ Section 3-1 of the *Aged Care Act 1997*.

¹²⁹ Hardy “Aged Care” [2002] *Australian Elder Law Review* 1 at 2.

that receive funding from the Australian Government are subject to the 1997 Act's provisions relating to formal accreditation and monitoring processes. The Aged Care Standards and Accreditation Agency (ACSAA) is responsible for the accreditation and monitoring processes, which are complemented by a Complaints Resolution Scheme and other sanctions under the Department of Health and Ageing. The ACSAA was established by the Australian Government, as a wholly owned Commonwealth company limited by guarantee. The ACSAA is the body appointed by the Department of Health and Ageing as the accreditation body within the meaning of Division 80 of the *Aged Care Act 1997*. The main functions of the ACSAA are to manage the accreditation and ongoing supervision of Australian Government funded aged care homes and to promote quality care by providing information and education services.¹³⁰ The ACSAA assesses residential aged care homes, which receive funding from the Australian Government, in accordance with the Accreditation Standards set down under the Quality of Care Principles 1997.

1.65 The Accreditation Standards do not dictate the ways in which care and services are to be provided by residential care providers, but they focus on the expected outcomes of the care, i.e. the improved quality of care for the resident. The Accreditation Standards are intended to provide a structured approach to the management of quality and represent clear statements of expected performance.¹³¹ The ambit of the ACSAA does not extend to the assessment and supervision of providers of domiciliary care or community care, or to residential care homes that do not receive Government subsidies.

1.66 The Aged Care Complaints Investigation Scheme (ACCIS) was established to manage complaints made about aged care services that are subsidised by the Australian Government.¹³² The ACCIS has authority to investigate concerns raised about the health and/or well-being of people receiving Government subsidised aged care. Any person receiving Government subsidised aged care, or their relative or guardians, can make a complaint to the ACCIS. Once a concern has been highlighted, the ACCIS investigates the concern and informs service providers if they are found not to be providing the appropriate care and services.

1.67 The ACCIS is managed by the Office of Aged Quality and Compliance (OAQC). The OAQC, located within the Department of Health and Ageing, is the body responsible for ensuring the quality and accountability of

¹³⁰ For more see www.accreditation.org.au.

¹³¹ www.accreditation.org.au.

¹³² For more information see www.health.gov.au under the Office of Aged Care Quality and Compliance section within the Aged Care section.

Australian Government subsidised aged care services.¹³³ The OAQC seeks to ensure the safety and security of people in aged care services by managing the ACCIS and regulating approved providers of Government subsidised aged care. It should be noted that the OAQC is currently working on a priority project which is looking to enhance the accreditation framework for residential aged care and the quality assurance arrangements for the community based aged care.

1.68 Finally, the Office of the Aged Care Commissioner (OACC) is responsible for investigating the ACCIS and the ACSAA.¹³⁴ The OACC reviews certain decisions made by the ACCIS and examines complaints about the ACCIS's processes. The OACC¹³⁵ investigates complaints made against aged care services which are subsidised by the Australian Government.¹³⁶ The Aged Care Commissioner is statutory appointed, and holds an office independent of the Department of Health and Ageing and the ACSAA. The functions of the OACC are set out in section 95A-1 of the 1997 Act and Part 6 of the Investigation Principles 2007.

(b) Regulation of Community Care Providers in Australia

1.69 A notable characteristic of community care in Australia is the relative lack of formal regulation. Australian Government policy places great emphasis on the provision of home care for older people who wish to remain in their homes. A broad range of home care packages and services are made available by the Commonwealth and by the individual States and Territories to older people in order to support their care at home. Care for older people still living in their own homes is largely funded through either Community Aged Care Packages (CACP) or the Home and Community Care services (HACC), jointly funded by the Commonwealth and the States.

1.70 Where community care is subsidised by the Australian government, the ACCIS has the power to investigate any complaints made by the service recipient or any relative or guardian of a recipient. The authority of the OAQC also extends to Government subsidised community care. Thus the OAQC can regulate approved providers of Government subsidised community care. The OACC can review certain decisions made by the ACCIS in relation to community care services which are subsidised by the Australian Government.

¹³³ For more detailed information see www.health.gov.au under the Office of Aged Care Quality and Compliance section within the Aged Care section.

¹³⁴ Section 95(2)(d)(i) of the *Aged Care Act 1997*.

¹³⁵ Section 95A of the *Aged Care Act 1997*.

¹³⁶ For more information see www.agedcarecommission.net.au.

1.71 The different types of community care packages available to older people in Australia are each treated differently in terms of investigation and accreditation. CACPs are individually planned and coordinated packages of care tailored to help older Australians with low-level care needs to remain living in their own homes. They are funded by the Australian Government to provide for the complex care needs of older people. Two other programmes, Extended Aged Care at Home (EACH) and Extended Aged Care at Home Dementia (EACHD), also provide services for high-level care needs at home. EACH and EACHD are individually planned and coordinated packages, tailored to help frail older Australians with high-level care needs to remain at home. These three care packages are funded by the Australian Government and as such are subject to the functions of the ACCIS, the OAQC and the OACC. Services, or subsidised services, provided by the Australian government are subject to the Quality of Care Principles.¹³⁷

1.72 Another community care package is the HACC service which aim to meet basic needs to maintain the person's independence at home and in the community. Types of HACC include community nursing, domestic assistance, personal care, meals on wheels, home modification and maintenance, transport and community-based respite care. HACC is funded jointly by the Commonwealth and by individual States, thus HACC does not fall under the Quality Care Principles. Instead there are national standards specifically for HACC.¹³⁸ Under these standards, all States and Territory Governments are now required to include the Standards in all service contracts. Monitoring and compliance with the Standards is now a major part of service reviews. The HACC National Service Standards Instrument has been developed to measure the extent to which individual agencies are complying with the Standards through a service appraisal process.¹³⁹

1.73 Many providers of community care operate quality control and complaints mechanisms, but there is no statutory requirement to do so. Thus consumers, while in the majority of cases well supported and cared for, very often are exposed potentially to variable service standards uncertainty about the background of staff they admit to their homes and have few if any avenues of complaint.¹⁴⁰

¹³⁷ Section 54 of the *Aged Care Act 1997*.

¹³⁸ Home and Community Care Program National Standards Instrument see www.health.gov.au.

¹³⁹ For more information see www.health.gov.au.

¹⁴⁰ Hardy "Aged Care" [2002] *Australian Elder Law Review* 1 at 2.

1.74 Services that provide CACP and EACH are required to take part in Quality Reporting, but not HACC programmes. Quality Reporting is the Australian Government's method of encouraging community care service providers to improve the quality of their service delivery. All community care service providers have to meet consistent Australian Government standards in the quality and delivery of services. Quality Reporting requires providers to report on how their services meet standards and other expectations. The focus of Quality Reporting is not on service delivery itself, but on the processes that systems providers have in place to ensure service quality, and how these might be improved. It is important to note that Quality Reporting is not about accreditation, but about accountability and improving service delivery.¹⁴¹ Under the Quality Reporting process, service providers complete a quality report, which is then sent to the Department of Health and Ageing for review. An officer from the Department then makes a physical inspection of the service provider and the final outcome of the report is sent to the service provider. Quality Reporting is part of an overall reform of community care in Australia, which is designed to strengthen community care and support its growing contribution to the lives of older Australians. The essence of the reforms is to streamline community care.¹⁴² A review of Quality Reporting in 2008 found that there had been significant achievements by the Department of Health and Ageing and service providers in continuous improvement in the quality of the services.¹⁴³

(5) Canada

1.75 Canada's health care system is highly evolved and comprehensive. Under the *Canada Health Act 1984* the aim of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.¹⁴⁴ The organisation of Canada's health care system is largely determined by Canadian Constitution which sets out the roles and responsibilities that are divided between the federal, and provincial and territorial governments.¹⁴⁵ Canada's publicly funded health care system provides universal coverage for medically necessary health care services for all Canadians. Health care is provided on the basis of need, rather than ability to

¹⁴¹ For more information see www.health.gov.au in the Quality Reporting section within the Community Care section.

¹⁴² "The Way Forward – A new strategy for Community Care", available at www.health.gov.au.

¹⁴³ For more information see www.agedcareaustralia.gov.au.

¹⁴⁴ Section 3 of the *Canada Health Act 1984*.

¹⁴⁵ *Constitution Act 1867*.

pay. The publicly-funded health care sector – known as “medicare” - is administered and delivered by the provinces and territories, and funded by the federal government under the 1984 Act.¹⁴⁶

1.76 Community care is a secondary health care service, though it is not covered by the *Canada Health Act 1984*. In response to both the increase in health care costs and public pressure, provinces and territories have developed a variety of different schemes for some aspects of home care, particularly end-of-life and palliative care. Funding for other parts of home care comes from a plethora of different payment schemes, with a wide mixture of public and private funding sources. The regulation of these programmes varies, as does the range of services between the different provinces and territories. Needs are assessed and services are coordinated to provide continuity of care and comprehensive care. The Federal Department of Veterans Affairs Canada provides home care services to certain veterans when such services are not available.

1.77 Care of vulnerable people has developed significantly in Canada in the last few decades. The concept of “assisted living” has formed a central part of Canada’s health care policy. Assisted living is a housing and care alternative for those who are no longer able to continue living in their own homes, but who do not need the level of care offered in residential care facilities. An assisted living residence provides hospitality services such as meals, social and recreational opportunities, and personal care in the form of assistance with activities of daily living or medications.¹⁴⁷

(a) British Columbia

1.78 In British Columbia, a range of care is available to vulnerable people, from residential care, to home care, to assisted living and independent living. In 2005, about 23,000 older persons in British Columbia received home nursing care and 26,000 received home support including non-medical personal care for the same period. In British Columbia, home nursing care is provided at no cost to the client, while home support services are income-tested, with clients paying on a sliding scale based on their income. About 73% of people receiving home support services pay no fee due to their low incomes.¹⁴⁸

¹⁴⁶ For more information see Ministry of Health *Canada’s Health Care System* available at www.hc-sc.gc.ca.

¹⁴⁷ Report of the Premier’s Council on Aging and Seniors’ Issues *Aging Well in British Columbia* at p.53 available at www.hls.gov.bc.ca/seniors/council.

¹⁴⁸ *Ibid* at p.50.

(i) Assisted living in British Columbia

1.79 In British Columbia, there are 114 registered assisted living residences, providing a total of 3,680 units.¹⁴⁹ An assisted living residence is a premises other than a community care facility in which housing, hospitality services and prescribed services are provided.¹⁵⁰ These prescribed services include regular assistance with activities of daily living, the administration and distribution of medication and the maintenance and/or management of a resident's finances or property.¹⁵¹ The Minister for Health in British Columbia appoints the assisted living registrar to register an assisted living residence if he or she is satisfied that the service will be provided in a manner that will not jeopardise the health and safety of service users.¹⁵² The registrar has the power to enter and inspect any assisted living premises if he or she has reason to believe that the health and safety of a resident is at risk.¹⁵³

1.80 Assisted living is available to adults who can live independently but require regular assistance with daily activities, usually because of age, illness or disability. Regulation of this sector is complaints-based and so any person seeking to avail of assisted living must be able to make decisions on their own behalf, unless a spouse lives with the person and is willing and able to make decisions on the person's behalf.¹⁵⁴ As with home support services and residential care, assisted living provided through the public health system has user fees that vary based on the resident's income. These charges never exceed 70% of a resident's after-tax income.¹⁵⁵

(ii) Independent living in British Columbia

1.81 The British Columbia Housing Management Commission ("BC Housing") was created in 1967 through an Order-in-Council. BC Housing is a provincial crown agency under the Ministry of Housing and Social Development.

¹⁴⁹ *Op cit* fn174 at 53.

¹⁵⁰ Section 1 of the *Community Care and Assisted Living Act 2003*.

¹⁵¹ Regulation 2 of the *Community Care and Assisted Living Regulations 2008*.

¹⁵² Section 25(1) of the *Community Care and Assisted Living Act 2003*.

¹⁵³ Section 25(2)(a) of the *Community Care and Assisted Living Act 2003*.

¹⁵⁴ For more information see department of Health *Home and Community Care: A Guide to Your Care, August 2007*, available of www.health.gov.bc.ca/hcc.

¹⁵⁵ Report of the Premier's Council on Aging and Seniors' Issues *Aging Well in British Columbia*, at p53.

The main objective of BC Housing is to create the best system of housing and support for vulnerable British Columbians.¹⁵⁶ One of the programmes operated by BC Housing is Independent Living in British Columbia. Independent living is a funding partnership programme between the Government of Canada and the Government of British Columbia that funds the construction of assisted living apartments.

1.82 Independent Living BC was created in 2002, serves seniors and people with disabilities who require some support but do not need 24 hour institutional care. It offers a middle ground to bridge the gap between home care and institutional care. Individuals cannot apply directly to an assisted living development. They must be assessed by their local health authority. In terms of cost, individuals pay up to, but no more than 70% of their after-tax income to live in assisted living homes. This provides them with accommodation, hospitality services and personal care. Independent living BC offers assisted living suites, that are self-contained, wheelchair accessible apartments. Independent senior's housing, assisted living homes and residential care facilities are available on the same site, allowing residents to move from one level of care to the next when the need arises.

1.83 The Ministry of Health Services in British Columbia also operates Choice in Supports for Independent Living ("CSIL") as an alternative for eligible home support clients. CSIL was developed to give British Columbians with daily personal care needs more flexibility in managing their home support services. CSIL is a self-managed model of care. Clients receive funds directly for the purchase of home support services. They assume full responsibility for the management, co-ordination and financial accountability of their services, including recruiting, hiring, training, scheduling and supervising home support workers. Seniors and people with disabilities who are unable or not always able to direct their own care can obtain CSIL funding through the formation of a client support group. A client support group consists of five people who have registered as a non-profit society for the purpose of managing support services on behalf of a CSIL client. This can include family members, friends and neighbours. The client support group takes on all the responsibilities of an employer. CSIL funds go directly to purchase home support services on behalf of their clients. CSIL clients have greater flexibility in their care options and may pay family members, except immediate family members, as care givers although health authorities may grant an exception for an immediate family member to be paid.

(iii) Community care facilities

¹⁵⁶ For more information see www.bchousing.org.

1.84 Under the *Community Care and Assisted Living Act 2003*, a “community care facility” is a premises in which a person provides care to three or more people, who are not related by blood or marriage to the care provider.¹⁵⁷ A person carrying on a community care facility must be licensed.¹⁵⁸ The Act also sets out certain standards which the licensee must maintain in terms of the staffing of the service and the health and safety of persons in care.¹⁵⁹

1.85 Community care facilities are inspected regularly to ensure compliance with the 2003 Act and *Adult Care Regulations* to determine if minimum health and safety requirements are being followed with respect to policies, staffing, resident care, building requirements and others. In addition, follow up is done in response to items that need to be corrected, complaints, allegations of abuse, and reportable incidents. The *Adult Care Regulations* set out specific standards in relation to employees.¹⁶⁰ A licensee must ensure that each of its employees who works in or about a community care facility has the personality, ability and temperament necessary to maintain the spirit, dignity and individuality of the person being care for.¹⁶¹ The employees must possess the training and experience necessary to carry out their duties and they must be physically and mentally competent in order to perform their duties.¹⁶²

(6) Conclusion

1.86 A unified approach to the regulation of all health care providers including domiciliary care providers is the approach favoured in England and Wales, and in Scotland and Northern Ireland. This approach gives consistency and reliability to the registration, regulation and inspection processes which all health care providers must undergo. In Australia, there are separate regulatory bodies for different the different types of health care providers. Also, where care is funded by the Australian Government that service falls under a different category of rules, separate from privately funded care or care funded by the individual states or territories. This approach is disjointed. While there are a number of different regulatory bodies, there appears to be no body responsible

¹⁵⁷ Section 1 of the *Community Care and Assisted Living Act 2003*.

¹⁵⁸ Section 5 of the *Community Care and Assisted Living Act 2003*.

¹⁵⁹ Section 7 of the *Community Care and Assisted Living Act 2003*.

¹⁶⁰ Regulation 6.1 of the *Adult Care Regulations 1980*. The 1980 Regulations were amended by B.C. Reg. 419/2008.

¹⁶¹ Regulation 6.1(a) of the *Adult Care Regulations 1980*.

¹⁶² For more information see www.hls.gov.bc.ca/seniors.

for the regulation of private domiciliary care providers, or private health care providers.

G Conclusion

1.87 This Chapter examined the factors which necessitate the regulation of domiciliary care providers. The lack of a statutory framework was identified as a problem which exposes older people to the possibility of abuse within their own homes. The discussion examined the role of HIQA in regulating health care providers, and it further investigated the extent to which HIQA's authority could be extended to include domiciliary care providers. The methods of regulating domiciliary care providers employed in other jurisdictions were then considered.

1.88 As an independent body, already charged with regulating and inspecting residential care providers, HIQA is in a prime position to perform the task of regulating domiciliary care providers. As discussed above, this could be achieved by amending various sections of the *Health Act 2007* to include the home care setting. Under section 8 of the 2007 Act, HIQA currently has the authority to set standards on safety and quality in relation to services provided by the HSE or services provided by a private nursing home. HIQA also has the authority to monitor the compliance of the different bodies with such standards, through the SSI under section 41 of the 2007 Act. By amending these relevant sections of the 2007 Act HIQA would be able to propose standards by which domiciliary care providers could be regulated and would reflect the Government's express policy of regulating both institutional and domiciliary sectors. These amendments would also enable SSI to register and inspect domiciliary care providers, to ensure that those providers are complying with the standards set down by HIQA.

1.89 In Chapter 2, the Commission turns to examine the legislative frameworks and detailed standards in place for domiciliary care providers in other States and the standards already drawn up by HIQA in relation to residential care providers.

CHAPTER 2 STATUTORY REGULATIONS AND STANDARDS

A Introduction

2.01 In Chapter 1 the Commission examined how the *Health Act 2007* could be amended to regulate domiciliary care providers. In this Chapter, the Commission examines the detailed content of such legislative arrangements. In this respect, Part B examines the approaches adopted in other jurisdictions in relation to home care regulations and standards. Part C examines the standards already set out by HIQA for the residential care sector, which indicate the key issues that are likely to arise in the domiciliary setting. In Part D the Commission sets out its conclusions and presents options for reform.

B Regulations and Standards: Other Jurisdictions

2.02 When considering what regulations and standards should be drawn up to regulate the domiciliary care sector in Ireland, it is useful to examine what regulations and standards are favoured by other jurisdictions. The model adopted in most of the jurisdictions where the domiciliary care sectors are regulated allows the appropriate Minister(s) or Department to compile regulations, compliance with which is mandatory, which make provision in relation to various different aspects of the service, including the management, staff and conduct of the agencies. In many of these jurisdictions the Minister(s) or Department also has the authority to publish minimum standards, which flesh out the regulations, and set a standard below which providers of domiciliary care cannot fall below.

2.03 In Ireland, the Minister for Health and Children has the authority to make regulations regarding the procedures to be followed by HIQA in setting standards for care providers.¹ The Minister may also make regulations for the purpose of ensuring proper standards in relation to designated centres. Such regulations may make provision in relation to the maintenance, care, welfare and well-being of persons resident in a designated centre, as well as other aspects of the provision of care.²

¹ Section 100 of the *Health Act 2007*.

² Section 101(2) of the *Health Act 2007*.

2.04 In order to determine the best approach for regulating domiciliary care in Ireland, it is important to examine the models adopted in other jurisdictions, and to look at what key areas of the service those regulatory frameworks make provision for.

(1) England

2.05 In England the Secretary of State for Health has the authority to impose regulations on establishments and agencies which provide health care, including domiciliary care agencies.³ Such regulations were drawn up in the *Domiciliary Care Agencies Regulations 2002*. These regulations govern the registration process and the operation of domiciliary care agencies. The *Care Standards Act 2000* also confers on the appropriate Minister the authority to publish statements of national minimum standards applicable to establishments and agencies.⁴ The *Domiciliary Care – National Minimum Standards* were published in 2003, to act as guidelines for the CQC when it is assessing whether an agency is complying with the regulations. The purpose of the minimum standards is to ensure as far as possible, that the quality of personal care which older people are receiving in their own home meets a certain minimum standard.⁵ The standards are considered to constitute a benchmark against which the services provided by agencies will be judged, but they are not incorporated into regulations.⁶ The *Care Standards Act 2000* requires that standards be taken into account by those making a decision about regulatory action or inaction in relation to any care establishment or agency.⁷

2.06 The distinction between regulations and standards was considered by the High Court of England and Wales in *Brooklyn House v Commission for Social Care Inspection*.⁸ There is nothing in the *Care Standards Act 2000* specifying that the standards must be complied with. This is in contrast to the regulations, breach of which is a trigger for de-registration and also constitutes a criminal offence.⁹ In the Brooklyn House case, the appellant argued that the respondent had used the national minimum standards to create an offence.

³ Section 22(1) of the *Care Standards Act 2000*.

⁴ Section 23 of the *Care Standards Act 2000*.

⁵ *Domiciliary Care – National Minimum Standards* at 3.

⁶ Ridout, “New Laws for the Regulation and Funding of Care”, *Elder Law and Finance*, 1.2 at 38.

⁷ Section 23(4)(a) of the *Care Standards Act 2000*.

⁸ 91 BMLR 22; 2006 EWHC 1165.

⁹ Mitchell, “Community Care Law update”, 156 *New Law Journal* 1608.

Dismissing the appellants' argument, the Court held that the national minimum standards do not create or define any offence under the regulations, rather they can be used to determine whether there had been a breach of the regulations.¹⁰ Thus, a domiciliary care agency will not be prosecuted for breaching the standards, but the standards will be taken into account when considering whether the agency has fulfilled its obligations under the regulations. The CSCI will consider the degree to which an agency is complying with the standards when determining whether or not a service should be registered or have its registration cancelled, or whether to take any action for breach of regulations.¹¹

(a) Domiciliary Care Agencies Regulations 2002

2.07 In England the Secretary of State for Health has the authority to publish National Minimum Standards for health care providers.¹² The *Domiciliary Care Agencies Regulations 2002* set out the procedures and processes to which public, private and voluntary domiciliary agencies must adhere. Under the 2002 Regulations, each agency must have a "registered person"¹³ to compile a written statement of purpose in relation to the agency, which should include the agency's aims and objectives, the nature of the services which the agency provides, the qualifications of the manager and of the domiciliary care workers, and a complaints procedure.¹⁴ A "registered person" means any person who is registered as the provider or manager of the agency.¹⁵ The registered person must also ensure that the agency is conducted in a manner that safeguards the service user from abuse and promotes the independence of each service user.¹⁶ The registered person is required to make a guide available to the service user, which must include information regarding the terms and conditions of the provision of the service and a summary of the complaints procedure.¹⁷

¹⁰ See judgment of Kay LJ.

¹¹ *Domiciliary Care – National Minimum Standards* at 4.

¹² Section 23 of the *Care Standards Act 2000*.

¹³ A registered person is any person who is registered as the provider or the manager of the agency as per section 2(1) of SI 3214/2002 *Domiciliary Care Agencies Regulations 2002*.

¹⁴ Schedule 1 of the *Domiciliary Care Agencies Regulations 2002*.

¹⁵ Regulation 2(1) of the *Domiciliary Care Agencies Regulations 2002*.

¹⁶ Regulation 13 of the *Domiciliary Care Agencies Regulations 2002*.

¹⁷ Regulation 5(1) of the *Domiciliary Care Agencies Regulations 2002*.

2.08 The regulations contain requirements to assure the quality of service provision. The registered person must ensure that all domiciliary care workers employed by the agency satisfy certain criteria.¹⁸ Each domiciliary care worker must be "...of integrity and good character", must possess the requisite skills and experience, and must be physically and mentally fit for the work.¹⁹ In addition, every domiciliary care worker must furnish the agency with specific personal and professional information, including details of any criminal offences, documentary evidence of relevant qualifications and a full employment history.²⁰ The domiciliary care agency must also ensure that personal care is provided in a manner that ensures the safety of service users and protects them from abuse or neglect.²¹ The agency must further ensure that personal care is delivered in a manner which promotes the independence of the service user and respects the privacy, dignity and wishes of the individual.²² Furthermore, the agency must ensure that it supplies the service in a manner which ensures the safety and security of the property of the service user.²³

2.09 The regulations set down specific instructions regarding the arrangements for the provision of personal care. The registered person must prepare a written plan, called the "service user plan". This plan should specify the needs of that individual and the plan should include details of the way in which those needs will be met by the provision of personal care.²⁴ The registered person must draw up the plan in consultation with the service user²⁵ and must take into account the wishes of the service user.²⁶ Once the service user plan has been formulated, it must be made available to the service user and should be kept under review.²⁷ The registered person then has responsibility to ensure that the agency provides a service that meets the needs of the service user as set out in the plan.²⁸ The registered person must also put

¹⁸ Regulation 12 of the *Domiciliary Care Agencies Regulations 2002*.

¹⁹ *Ibid.*

²⁰ Schedule 3 of the *Domiciliary Care Agencies Regulations 2002*.

²¹ Regulation 13(a) and (b) of the *Domiciliary Care Agencies Regulations 2002*.

²² Regulation 13(c) and (e) of the *Domiciliary Care Agencies Regulations 2002*.

²³ Regulation 13(d) of the *Domiciliary Care Agencies Regulations 2002*.

²⁴ Regulation 14(2) of the *Domiciliary Care Agencies Regulations 2002*.

²⁵ Regulation 14(3)(c) of the *Domiciliary Care Agencies Regulations 2002*.

²⁶ Regulation 14(5)(a) of the *Domiciliary Care Agencies Regulations 2002*.

²⁷ Regulation 14(3)(a) and (b) of the *Domiciliary Care Agencies Regulations 2002*.

²⁸ Regulation 14(4) of the *Domiciliary Care Agencies Regulations 2002*.

in place procedures to make sure that medicines are properly administered.²⁹ The regulations require that arrangements are made for the recording, handling, safe keeping, safe administration and disposal of medicines used in the provision of personal care.³⁰ Registered persons are also required to ensure that care workers have received the appropriate training, so that they can operate a safe system of working.³¹

2.10 Where the agency arranges for the provision of personal care to a service user, the registered person must ensure that arrangements specify the procedure to be followed where the service user makes an allegation of elder abuse.³² The registered person must also ensure that the arrangement specifies the circumstances in which the care worker may administer or assist in the administration of the service user's medication. Importantly, the registered person must also ensure that the agreement specifies the financial arrangement that exists where the care worker acts as an agent for, or receives money from a service user.³³

2.11 The regulations set down specific requirements in relation to the qualifications and training of care workers.³⁴ The registered person is responsible for ensuring that, at all times, the agency retains an appropriate number of suitably skilled persons for the purposes of the agency.³⁵ The registered person must ensure that the care worker has all the necessary information relating to the service user and their specific needs, and that the care worker receives assistance where needed in order to provide the appropriate level of personal care.³⁶ Each care worker must receive training appropriate to the type of work that they perform³⁷ and the registered person should encourage the care workers to obtain appropriate qualifications.³⁸

²⁹ Regulation 14(7) of the *Domiciliary Care Agencies Regulations 2002*.

³⁰ *Ibid.*

³¹ Regulation 14(8) of the *Domiciliary Care Agencies Regulations 2002*.

³² Regulation 14(6) of the *Domiciliary Care Agencies Regulations 2002*.

³³ Regulation 14(6)(d) of the *Domiciliary Care Agencies Regulations 2002*.

³⁴ Regulation 15 of the *Domiciliary Care Agencies Regulations 2002*.

³⁵ Regulation 15(1)(a) of the *Domiciliary Care Agencies Regulations 2002*.

³⁶ Regulation 15(1)(b) and (c) of the *Domiciliary Care Agencies Regulations 2002*.

³⁷ Regulation 15(2)(a) of the *Domiciliary Care Agencies Regulations 2002*.

³⁸ Regulation 15(2)(b) of the *Domiciliary Care Agencies Regulations 2002*.

2.12 Importantly, the regulations provide for the establishment of a complaints procedure.³⁹ This procedure allows service users, or someone acting on their behalf, to make a complaint to the registered person and ensures that the complaint is dealt with in an appropriate and efficient manner. A written copy of the procedure is to be drawn up and supplied to each service user. This written copy must include the contact details of the CSCI and the specific details of the complaints procedure.⁴⁰ It is the responsibility of the registered person to ensure that every complaint is fully investigated.⁴¹ The complainant must be informed of what action is being taken in response to the complaint, within at least 28 days of the complaint being made.⁴² A record, containing details of all the investigations made into the complaint and any outcome, must be kept by the registered person, and a summary of all complaints made in a twelve month period must be submitted to the CSCI.⁴³

(b) Domiciliary Care: National Minimum Standards

2.13 In 2003, the Department of Health in England published the “*Domiciliary Care: National Minimum Standards*”, which set out the minimum standard of service required of domiciliary care agencies under the 2000 Act. The standards apply to all providers of personal domiciliary care services in the private, voluntary and public sectors. However, where an agency is acting as an employment agency and introduces the care worker to the service user, then some of the standards will not apply to such agencies. Where an agency operates from more than one branch, then each branch must register. Similarly, where the agency is a franchise operation, each individual franchise is treated as a business and will be required to register separately.⁴⁴

2.14 The standards apply to agencies that provide care to a wide range of people including older people, people with physical disabilities and people with learning disabilities. These standards flesh out the regulations, by setting out specific details with regard to the personal care of the service user and in particular attention is paid to the drawing up of the service user’s plan.⁴⁵ The

³⁹ Regulation 20 of the *Domiciliary Care Agencies Regulations 2002*.

⁴⁰ Regulation 20(3)(a) and (b) of the *Domiciliary Care Agencies Regulations 2002*.

⁴¹ Regulation 20(4) of the *Domiciliary Care Agencies Regulations 2002*.

⁴² Regulation 20(5) of the *Domiciliary Care Agencies Regulations 2002*.

⁴³ Regulations 20(6) and 20(7) of the *Domiciliary Care Agencies Regulations 2002*.

⁴⁴ Department of Health *Domiciliary Care: National Minimum Standards* at 5, available at www.dh.gov.uk/en/Publicationsandstatistics.

⁴⁵ Standard 7 of the *Domiciliary Care: National Minimum Standards*.

standards are broad, but they reflect the unique and complex needs of individuals. Domiciliary care agencies are required to respect the privacy, dignity, autonomy and independence of the service user when providing the care.⁴⁶ The standards also set out the specific measures that must be followed in order to protect the service user from abuse or exploitation.⁴⁷ Minimum requirements with regard to the development and training of domiciliary care workers are also established.⁴⁸

2.15 There are five main categories under which the standards fall; (i) user focused services, (ii) personal care, (iii) protection, (iv) management and staffing and (v) organisation of the business.

(i) User focused services

2.16 Central to the policy objective of maintaining a person's independence, is the need to keep service users informed of all aspects of their care. This enables service users to participate in the process by making informed decisions regarding their care, thereby maintaining their independence. The aim of the user focused services standards is to ensure that the rights, privacy and dignity of the individual are respected in the provision of care.

2.17 Under the user focused service standards, registered providers are required to produce a statement of purpose and a service user's guide that sets out the aims and objectives of the agency and the nature of the services to be provided.⁴⁹ This guide must be provided to all service users and their carers. The guide must include an overview of the delivery of care, and key contract terms and conditions, and must detail the complaints procedure.⁵⁰ The registered person must be able to demonstrate the capacity of the agency to meet the service user's needs, by ensuring that staff have the requisite skills and experience to deliver the care. This affirmation reassures the service user that the agency is able to meet their care needs. Care workers are required to arrive at the service user's home at a specific time, with a slight window for flexibility. Also, care workers are only changed for legitimate reasons, such as

⁴⁶ Standards 8 and 9 of the *Domiciliary Care: National Minimum Standards*.

⁴⁷ See standards 11-15 of the *Domiciliary Care: National Minimum Standards*.

⁴⁸ See standards 18-20 of the *Domiciliary Care: National Minimum Standards*.

⁴⁹ Standard 1 of the *Domiciliary Care: National Minimum Standards*, in accordance with regulations 4 and 5 of the *Domiciliary Care Agencies Regulations 2002*.

⁵⁰ Standard 1.2 of the *Domiciliary Care: National Minimum Standards*.

sick leave or annual leave. These requirements ensure that the service user receives a consistent and reliable personal care service.⁵¹

2.18 Importantly, specific provision is made in the standards for the requirement to provide each service user with an individual service contract within seven days of commencement of the service.⁵² The contract should detail the specific details of the service that the domiciliary care worker will and will not undertake, and the level of flexibility involved in the provision of personal care. The financial arrangement between the service user and the agency and the method of payment should also be detailed. The arrangements for monitoring and reviewing the needs of the service user must also be outlined in the contract, as well as the process by which the staff are monitored and supervised. Practical issues, such as holiday cover and protocol for entering and leaving the premises, should also be explicitly stated in the contract.

2.19 The fact that the standards require the service user and the agency to agree a contract, is significant, as it strengthens the service user's position. The contract is a document which both the service user and the care worker can refer to in order to resolve any issues regarding the nature of the care that may arise. The service user can rely on the contract to determine what exactly he or she can expect a carer to provide. Under the contract, the service user is certain of their own rights and responsibilities. This standard will be examined in more detail in the context of Chapter 3

(ii) Personal care

2.20 The term "personal care" is not defined under the *Care Standards Act 2000*, but the standards provide some instruction as to what type of care comes under the umbrella of personal care.⁵³ Under this, personal care includes (i) assistance with bodily functions, (ii) care requiring physical and intimate touching, but not as much as assisting with bodily functions, (iii) non-physical care and (iv) emotional and psychological support.⁵⁴ The Department of Health have set out that it is only where an agency is providing care coming under the first two categories that the agency will be required to register in accordance with the *Care Standards Act 2000*.⁵⁵

⁵¹ Standard 6 of the *Domiciliary Care: National Minimum Standards*.

⁵² Standard 4 of the *Domiciliary Care: National Minimum Standards*.

⁵³ *Domiciliary Care: National Minimum Standards* at 5.

⁵⁴ *Domiciliary Care: National Minimum Standards* at 5-6.

⁵⁵ Department of Health *Supported Housing and Care Homes: Guidance on Regulation* at 4, available at www.dh.gov.uk/publications.

2.21 As the purpose of providing domiciliary care is to maintain a person's independence at home, the standards seek to ensure that personal care is delivered in a manner that respects the dignity and privacy of the service user at all times. Thus, the standards require that a personal service user plan be developed and agreed with each service user. The plan should be drawn up in liaison with the service user or, where that is not possible with the service user's representative. The plan should outline the specific arrangements for the delivery of care, and should take account of the needs and wishes of the service user.

2.22 In seeking to protect the dignity and privacy of the service user, the personal care standards seek to ensure that care is provided in a manner that respects and promotes the welfare of the service user. In particular, the standards require that when a care worker is assisting the service user with dressing, washing, toilet and continence requirements and other tasks, the care worker must have due regard for the service user's dignity and privacy.⁵⁶

2.23 The standards also require agency managers and care workers to do all they can to assist the service user in making their own decisions with regard to their care. Care workers are required to provide the service user with information and assistance in order to enable them to make these decisions.⁵⁷ These standards promote and maintain the service user's autonomy and independence.

(iii) Protection

2.24 As already discussed in Chapter 1, the threat of elder abuse increases where care is provided in a domiciliary setting. The protection standards impose specific requirements in order to protect the service user from abuse or exploitation. Firstly, a risk assessment must be carried out by the agency; this assessment should consider the risks associated with the delivery of the service, any risks in assisting with the administration of medicine and any risks associated with travelling to and from the service user's home.

2.25 The standards require that domiciliary care agencies and care workers take steps to protect service users from elder abuse, by drawing up written policies and procedures.⁵⁸ The registered person is required to ensure that the agency has clear procedures to deal with any suspicion or evidence of

⁵⁶ Standard 8 of the *Domiciliary Care: National Minimum Standards* in accordance with regulation 14 of the *Domiciliary Care Agencies Regulations 2002*.

⁵⁷ Standard 9 of the *Domiciliary Care: National Minimum Standards* in accordance with regulation 14 of the *Domiciliary Care Agencies Regulations 2002*.

⁵⁸ Standard 14.1 of the *Domiciliary Care: National Minimum Standards*.

abuse or neglect, in order to protect service users. Allegations of abuse must be investigated efficiently and the details must be recorded.⁵⁹

2.26 The protection standards also seek to protect the finances of service users, by requiring the registered person to draw up strict policies and procedures for staff on the handling of service user's money.⁶⁰ These policies and procedures should take account of the financial arrangement that is in place for payment of the service. The standards preclude any staff member from being involved in the making of or benefiting from a service user's will.⁶¹ Care workers are also prohibited from accepting gifts or cash from service users. The registered person is also required under the standards to ensure that there are procedures in place within the agency to fully investigate all allegations of financial irregularity, and that proper records of all financial transactions are maintained.

(iv) Management and staffing

2.27 Managers and staff play an elemental role in ensuring that service users receive a high level of care and that their privacy and dignity is respected. Service users expect a high quality of care from domiciliary care agencies. The quality of care provided is strongly influenced by the managers of the agency, and their ability to perform their responsibilities effectively. One of their main responsibilities involves appraising staff and ensuring that they are regularly supervised.⁶² Managers must ensure that only the most competent and qualified people are recruited, so as to protect the well-being, health and security of service users.

2.28 Managers must ensure that there is a rigorous recruitment and selection procedure in place, in order to protect the well-being of the service users. Anyone applying for a job as a domiciliary care worker must go through an interview process and if selected, they must then produce satisfactory references and complete certain training and qualification verifications and other vetting procedures.⁶³ Staff are required to reveal any previous criminal

⁵⁹ Standard 14.3 of the *Domiciliary Care: National Minimum Standards*.

⁶⁰ Standard 13 of the *Domiciliary Care: National Minimum Standards* in accordance with regulation 14 of the *Domiciliary Care Agencies Regulations 2002*.

⁶¹ Standard 13.2 of the *Domiciliary Care: National Minimum Standards*.

⁶² Standard 21 of the *Domiciliary Care: National Minimum Standards*.

⁶³ Standard 20 of the *Domiciliary Care: National Minimum Standards*.

convictions they may have.⁶⁴ In return, all staff must receive a written description of their job, which identifies their specific responsibilities.⁶⁵

2.29 The standards endeavour to ensure that personal care is delivered by suitably qualified and competent staff. The standards make detailed requirements as to the level of training and qualifications that all staff members possess as a minimum. The registered person must ensure that all staff are trained sufficiently in order to provide the services of the agency.⁶⁶ All staff must hold a recognised care qualification.⁶⁷ Staff who do not possess an approved care qualification must obtain one within the first six months of employment.⁶⁸ Managers must also possess an approved management qualification and, if they don't already possess one, then they must obtain one within three years of employment.⁶⁹ Managers must undertake periodic training to update their knowledge, skills and competence.⁷⁰

(v) Organisation of the business

2.30 The delivery of effective domiciliary care requires a clear infrastructure which identifies all policies and procedures supporting service delivery. The standards require domiciliary care agencies to be organised in a manner that allows the business to operate efficiently and to meet the requirements of regulations and the standards. The delivery of the service must be supported by continuous monitoring and evaluation. The standards also require that each agency has a system in place that enables service users to make a formal complaint about the service, and for the complaint to be investigated promptly.⁷¹ These requirements are to ensure that service users receive a consistent, well-managed and planned service.⁷²

⁶⁴ Standard 17 of the *Domiciliary Care: National Minimum Standards* sets out all the various checks that potential staff must satisfy before the contract of employment can be completed.

⁶⁵ Standard 18 of the *Domiciliary Care: National Minimum Standards*.

⁶⁶ Standard 19.1 of the *Domiciliary Care: National Minimum Standards*.

⁶⁷ Standard 20.2 of the *Domiciliary Care: National Minimum Standards*.

⁶⁸ Standard 20.2 of the *Domiciliary Care: National Minimum Standards*.

⁶⁹ Standard 20.5 of the *Domiciliary Care: National Minimum Standards*.

⁷⁰ Standard 20.7 of the *Domiciliary Care: National Minimum Standards*.

⁷¹ *Domiciliary Care: National Minimum Standards* at 35.

⁷² Standard 22 of the *Domiciliary Care: National Minimum Standards* in accordance with regulation 22 of the *Domiciliary Care Agencies Regulations 2002*.

(2) Wales

2.31 The *Care Standards Act 2000* applies to Wales, and the National Assembly of Wales (NAW) has the general duty of encouraging improvement in the quality of care services, including domiciliary care agencies, provided in Wales. Under the 2000 Act, the appropriate Welsh Minister has the authority to impose regulations in relation to establishments and agencies⁷³ and to draw up national minimum standards for care service providers.⁷⁴ The *Domiciliary Care Agencies (Wales) Regulations 2004* were drawn up and enforced on the 1st March 2004. The regulations sets out the framework under which domiciliary care providers can operate.

2.32 The National Minimum Standards for Domiciliary Care Agencies in Wales were published in 2007. The Welsh standards form the criteria by which the CSIW will determine whether the agency provides personal care to the required standard. The standards establish a minimum below which an agency providing personal care for people living in their own homes cannot fall. The standards are measurable, they form the mark against which the quality of care can be measured. They are qualitative, as they provide a tool for judging the quality of care. The standards and the regulatory framework within which they operate should be viewed in the context of the NAW's overall policy objectives for supporting people in their own home.⁷⁵

(a) Domiciliary Care Agencies (Wales) Regulations 2004

2.33 The regulations themselves focus on the rights of the service user. The regulations seek to promote the independence of the individual and to encourage them to participate in all decisions regarding their care. In this regard, the registered person is required to make suitable arrangements to ensure that the agency is conducted, and the personal care is provided in a manner that ensures the safety of the service user,⁷⁶ and promotes their independence.⁷⁷ The regulations require the service provider to consult with the service user when preparing a written care plan for them.⁷⁸ At every stage of the provision of care, the service provider must provide the service user with all the

⁷³ Section 22(1) of the *Care Standards Act 2000*.

⁷⁴ Section 23(1) of the *Care Standards Act 2000*.

⁷⁵ Welsh Assembly Government *National Minimum Standards for Domiciliary Care Agencies in Wales*, piii-ix, available at www.csiw.wales.gov.uk/docs.

⁷⁶ Regulation 13(a) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁷⁷ Regulation 13(c) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁷⁸ Regulation 14(1) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

information necessary for them to make decisions with respect to their personal care.⁷⁹ This promotes the independence of the service user, and respects their dignity and individuality. Service providers are required to produce a written guide to the agency.⁸⁰ This guide should contain a statement of the aims and objectives of the agency,⁸¹ the complaints procedures⁸² and should also set out the terms and conditions upon which personal care is to be provided to service users.⁸³ This guide informs the service user about how the agency operates and what to do if there are any difficulties with the provision.

2.34 The regulations also make certain provisions in relation to management and staffing.⁸⁴ The regulations set out requirements in relation to the fitness of all care workers,⁸⁵ all managers⁸⁶ and all registered persons.⁸⁷ In general, all such persons are required to be of integrity and good character, physically and mentally fit, and they must provide evidence of qualifications, references and complete a vetting process.⁸⁸ The registered person is required to ensure that at all times an appropriate number of suitably qualified, skilled and experienced persons are employed for the purposes of the agency.⁸⁹ The registered person must also ensure that all staff receive training which is appropriate to the work they are carrying out,⁹⁰ and that if necessary an employee can be given time off in order to obtain appropriate further qualifications.⁹¹

⁷⁹ Regulation 14(4) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁰ Regulation 5 of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸¹ Regulation 5(1)(a) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸² Regulation 5(1)(e) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸³ Regulation 5(1)(c) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁴ Regulations 8-11;15,16 of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁵ Regulation 15 of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁶ Regulation 10 of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁷ Regulation 8(2) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁸ For more details on the criteria an employee must satisfy, see Schedule 2 of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁸⁹ Regulation 16(1)(a) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁹⁰ Regulation 16(2)(a) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

⁹¹ Regulation 16(2)(b) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

2.35 The regulations, by and large, replicate the provisions set down in the English standards.

(b) National Minimum Standards for Domiciliary Care Agencies

2.36 The Welsh standards form the criteria by which the CSIW will determine whether the agency provides personal care to the required standard. The standards encourage service users to do as much as possible for themselves in order to maintain their independence and physical ability. The text of the National Minimum Standards for Domiciliary Care Agencies in Wales is heavily based on the English domiciliary care standards. In fact, for most of the document the exact same text is used in the Welsh standards as is used in the English standards, with only slight variations in some parts. Thus, the analysis of the English standards also applies here, and there is no reason to repeat the discussion here.

2.37 However, there is one noticeable difference between the two sets of standards. In the English standards specific reference is made to the service contract that each service user must be issued with, which is signed by the service user and the registered manager of the care service.⁹² In the Welsh standards, this “service contract” is only referred to as a “statement of terms and conditions”.⁹³ The two documents are identical, except for their title. Both documents must be signed by both the service user and the service provider. Both documents must set out specific information regarding the care arrangement, including the method of payment, the rights and responsibilities of both parties, and the processes for monitoring and reviewing the service. There is a slight difference in the two standards, in that, the Welsh standard requires the service user to be provided with the statement of terms and conditions *before* the service begins.⁹⁴ Whereas the English standards require that the service user be furnished with the written contract within seven days of commencement of the service.⁹⁵ Perhaps the fact that the English standards refer specifically to a “contract” places English service users in a stronger position than their Welsh counterparts, who receive a “statement of terms and conditions”.

(3) Scotland

⁹² Standard 4 of the *Domiciliary Care: National Minimum Standards*.

⁹³ Standard 5 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

⁹⁴ Standard 5.1 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

⁹⁵ Standard 4.1 of the *Domiciliary Care: National Minimum Standards*.

2.38 Under the *Regulation of Care (Scotland) Act 2001*, Scottish Ministers have the authority to draw up regulations which may impose requirements on care service providers.⁹⁶ Scottish Ministers established the National Care Standards Committee, which then became the Care Standards and Sponsorship Branch (CSSB). The CSSB is responsible for publishing and reviewing national standards for care services. These standards must be taken into account by the Care Commission when it is deciding upon any application for registration. The standards are to be used to monitor care service providers, and to determine whether the providers are complying with the 2001 Act and the regulations.⁹⁷ If, during an investigation by the Care Commission, it is found that a service provider is not meeting the standards, then it must make a decision on whether to take enforcement action. In extreme cases where the service provider does not make any improvements to the service as directed by the Care Commission, the Care Commission may cancel the registration of the service provider. In some cases, failing to comply with a regulation will be an offence. However, failure to satisfy a standard, while considered to be a serious matter, will not be an offence, but may constitute evidence of a failure to comply with a regulation, which could be found to be an offence.

(a) Regulation of Care Scotland Regulations 2002

2.39 The Scottish Ministers have the authority to draw up regulations which may impose requirements on care services,⁹⁸ in order to secure the welfare of persons provided with a care service.⁹⁹ Such regulations were drawn up in the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*. These regulations apply to domiciliary care agencies. The objectives of these regulations are to promote and respect the independence and individuality of service users and to provide the service users with a choice as to the service they receive.¹⁰⁰

2.40 The regulations provide for the protection of the health and welfare of service users. Providers are required to provide their service in a manner which

⁹⁶ Section 29(1) of the *Regulation of Care (Scotland) Act 2001*.

⁹⁷ Care Standards and Sponsorship Branch *National Care Standards: Care at Home* Scottish Executive at 10, available at www.infoscotland.com/nationalcarestandards.

⁹⁸ Section 29(1) of the *Regulation of Care (Scotland) Act 2001*.

⁹⁹ Section 29(2)(e) of the *Regulation of Care (Scotland) Act 2001*.

¹⁰⁰ Regulation 2 of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

respects the privacy and dignity of service users.¹⁰¹ Service providers are required to prepare a written plan, in consultation with the service user, setting out how the service is going to meet the needs of the user.¹⁰²

2.41 The regulations set out certain requirements in relation to the management and staffing of the care service. All managers and care workers must be fit to perform the requirements of their jobs. Persons who are not of integrity and good character, who have been convicted of a criminal offence, or who have been adjudged bankrupt, shall be deemed to be unfit to be a care worker or to manage a care service.¹⁰³ Such persons must also be physically and mentally fit, and must have sufficient skills and experience in order to provide a care service.¹⁰⁴

2.42 Providers of care services must ensure that there are sufficient numbers of qualified and competent persons employed within the agency in order to guarantee that the needs of service users are met.¹⁰⁵ Service providers must also ensure that all employees receive appropriate training and assistance to gain further training.¹⁰⁶ These requirements ensure that service users receive the best care from qualified care workers.

2.43 The regulations also require service providers to keep records of the personal details of service users and employees.¹⁰⁷ In addition, providers are also required to establish a complaints procedure to fully investigate any complaints made by a service user or their representative.¹⁰⁸ A written copy of

¹⁰¹ Regulation 4(1)(b) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰² Regulation 5(1) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰³ Regulation 6(2)(a),(b),(c) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰⁴ Regulations 7(2)(c)(d) and 9(2)(a)(b) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰⁵ Regulation 13(b) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰⁶ Regulation 13(c)(i)(ii) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰⁷ Regulation 19(1),(2) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹⁰⁸ Regulation 25(3) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

the complaints procedure must be supplied to service users and their representatives if requested¹⁰⁹ and a summary of all complaints made in a year must be supplied to the Care Commission.¹¹⁰

2.44 The regulations set out certain requirements in relation to the utility of physical restraints on service users. Service providers must be certain that no service user is subjected to physical restraint, unless there are exceptional circumstances, or where restraint is the only practicable method of protecting the welfare of the service user. Providers are required to maintain a record of any occasion on which restraint or control has been applied to a user. Full details of the incident must be included in the report, including the reason why restraint was necessary.

(b) National Care Standards: Care at Home

2.45 The Scottish Ministers established the Care Standards and Sponsorship Branch for the purposes of publishing and reviewing national care standards. The Branch operates as a link between the Scottish Government and the Care Commission. In drawing up “National Care Standards: Care at Home”, the Branch consulted with various interest groups, and developed user focused standards. The standards are based on principles which recognise the rights of service users. The standards seek to protect the dignity and privacy of the service user and aim to enable service users to make their own choices when it comes to their care. The purpose of the standards is to enable service users, or their representatives, to refer to them in order to determine if they are receiving an appropriate level of service. Similarly, service providers can refer to the standards in order to determine what exactly is expected of them when they are providing care.

2.46 The standards can be organised into different categories; (i) user focused services, (ii) personal care, (iii) managers and staff and (iv) protection.

(i) User focused services

2.47 The aim of the standards is to enable service users to make their own decisions about their care. Service users are to be presented with an introductory pack that sets out the objectives of the service, details how the service is to be provided, sets out the financial arrangement for the provision of the services and sets out the complaints procedure.¹¹¹ The standards require

¹⁰⁹ Regulation 25(5) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹¹⁰ Regulation 25(7) of the *Regulation of Care (Requirements as to Care Services) Scotland Regulations 2002*.

¹¹¹ Standard 1.1 of the *National Care Standards: Care at Home*.

that a written agreement be drawn up, in consultation with the service user, setting out how the service will meet the specific needs of the service user. The terms and conditions of the service provision will be set out in this agreement.¹¹² The agreement takes account of all aspects of the service provision, including what services exactly are to be provided and what the financial arrangements are.

2.48 The standards require that every effort be made by the service provider to encourage the service user to participate in the care process, and to express their views on any aspect of the service.¹¹³ If the service user has communication difficulties, or does not speak English, then help must be provided to assist the service user in effectively communicating their views.¹¹⁴ The service user may to make a complaint and can expect that it will be dealt with by the service provider quickly and sympathetically.¹¹⁵

2.49 The main focus of the Scottish standards is on the provision of care in a manner which respects the service user's individuality. In this regard, the standards make explicit reference to the social, cultural and religious beliefs of service users. Care workers must be informed about, and have respect for, the social, cultural and religious beliefs of the service user.¹¹⁶ The care worker must support the service user in practicing their beliefs and must assist him/her in celebrating holy days and festivals.¹¹⁷ The standards further require care workers to cater to the service user's food choices and preferences.¹¹⁸ The care worker must cater for any ethnic, cultural or special dietary requirements that the service user may have.

(ii) Personal Care

2.50 The Scottish standards seek to ensure that personal care is delivered in a manner which respects the privacy and dignity of the service user. Care workers must have regard for the privacy of the service user and their homes at

¹¹² Standard 2 of the *National Care Standards: Care at Home*.

¹¹³ Standard 11 of the *National Care Standards: Care at Home*.

¹¹⁴ Standard 10.2 of the *National Care Standards: Care at Home*.

¹¹⁵ Standard 11.3 of the *National Care Standards: Care at Home*.

¹¹⁶ Standard 5.1 of the *National Care Standards: Care at Home*.

¹¹⁷ Standard 5.3 of the *National Care Standards: Care at Home*.

¹¹⁸ Standard 6.1 of the *National Care Standards: Care at Home*.

all times.¹¹⁹ Importantly, care workers are required to ensure that they respect the service user's dignity and privacy when providing personal care.¹²⁰

2.51 The standards further provide that the service provider must draw up a personal plan, detailing the needs and personal preferences of the service user and how those needs should be met.¹²¹ The personal plan will include details such as the service user's personal preferences as to food and drink, their social, cultural and spiritual preferences, their leisure interests and any communication needs. Service users can ask for their personal plan to be reviewed at any time.¹²² These standards ensure that the care being provided is specifically tailored to the individual service user, and that they are involved in the process as much as possible. These standards respect the service user as an individual and promote their independence.

2.52 Service providers are also required to record the details of any medication needed by the service user, in their personal plan.¹²³ The care worker is further required to maintain a record of the medication administered in the service user's home. If a service user is unable to administer their medication themselves, then the service provider must ensure that arrangements are in place to enable the care worker to assist the service user with the administration, or to do it for them.¹²⁴ The standards also require that the care workers have the appropriate skills to provide the personal care and nursing tasks needed to maintain the service user's health.¹²⁵ Where a service user falls ill, the care worker must take the appropriate action, and contact the emergency services if needed.¹²⁶

(iii) Protection

2.53 Unlike the English standards, which make specific and detailed provision in relation to the protection of the service user, the Scottish standards make little reference to the protection of service users. Service providers are required to monitor all aspects of the service, especially the quality of the

¹¹⁹ Standard 9.3 of the *National Care Standards: Care at Home*.

¹²⁰ Standard 9.6 of the *National Care Standards: Care at Home*.

¹²¹ Standard 3 of the *National Care Standards: Care at Home*.

¹²² Standard 3.3 of the *National Care Standards: Care at Home*.

¹²³ Standard 8.1 of the *National Care Standards: Care at Home*.

¹²⁴ Standard 8.3 of the *National Care Standards: Care at Home*.

¹²⁵ Standard 7.2 of the *National Care Standards: Care at Home*.

¹²⁶ Standard 7.4 of the *National Care Standards: Care at Home*.

service.¹²⁷ This is a very vague form of protection. There is no detail as to what providers are specifically required to monitor and in what way the monitoring is to be carried out. Providers are also required to ensure that records are maintained of all financial transactions involving staff members.¹²⁸ The Care Commission can inspect these records at any time.

2.54 In the English standards, protection of the service user from abuse or exploitation is given a paramount importance.¹²⁹ The standards recognise the important role that home care workers play in recognising and protecting people from abuse. Care workers are recognised as having a key role in minimising the likelihood of abusive situations occurring. The English standards seek to protect the service user by making detailed provision relating to safe working practices, by requiring that a risk assessment be carried out and by making explicit provision relating to the physical and financial protection of the service user.¹³⁰ In comparison to the English standards, it is clear that the Scottish standards do not go far enough to protect the welfare of the service user.

(iv) Management and Staff

2.55 In seeking to ensure that service users receive a high quality of care that is suited to their individual needs, the standards set down certain requirements in relation to the management and staffing of the care service.¹³¹ All staff involved in the home care service must have the requisite skills and competence to perform the duties of the service. Furthermore, care workers must be hired through an interview process and must provide satisfactory references, as well as completing a vetting process.¹³² In addition, staff must have regular training in order to update their skills. The service must be operated in accordance with all applicable legal requirements and best-practice guidelines. The service provider must ensure that the service has policies and procedures to cover the administration of medication, the recording of incidents and complaints and the management of risk.¹³³

(4) Northern Ireland

¹²⁷ Standard 4.5 of the *National Care Standards: Care at Home*.

¹²⁸ Standard 4.4 of the *National Care Standards: Care at Home*.

¹²⁹ See standards 11-15 of the *Domiciliary Care: National Minimum Standards* for a more detailed discussion.

¹³⁰ See standards 11-15 of the *Domiciliary Care: National Minimum Standards*.

¹³¹ Standard 4 of the *National Care Standards: Care at Home*.

¹³² Standard 4.3 of the *National Care Standards: Care at Home*.

¹³³ Standard 4.1 of the *National Care Standards: Care at Home*.

2.56 The *Domiciliary Care Agencies Regulations (Northern Ireland) 2007* and the minimum standards for domiciliary care agencies focus on ensuring that people using the services provided are protected and that the care being provided is of a certain minimum standard. Compliance with the regulations is mandatory, and non-compliance with some specific regulations is considered an offence.

(a) *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*

2.57 The Northern Ireland Department of Health, Social Services and Public Safety has the authority to impose regulations in relation to establishments and agencies as it sees fit.¹³⁴ This authority was used to set down the 2007 Regulations which came into operation on the 30th April 2007. These regulations make detailed provision as to the obligations and responsibilities that domiciliary care providers owe to the service users. Under the regulations the registered person must compile a written statement of the aims and objectives of the agency, and must furnish a copy of this statement to the RQIA.¹³⁵ The registered person is also responsible for producing a written service user's guide, which records the details of the care arrangement, including the terms and conditions of the service provision and the method of payment.¹³⁶ One of the greatest responsibilities that the registered person has is to ensure that the agency is conducted in a manner that guarantees the safety and well-being of the service users, protects them from abuse, and promotes their independence.¹³⁷ The regulations further require the registered person to ensure that the service is provided in a manner that respects the privacy and dignity of service users.¹³⁸ A complaints procedure must be established by the registered person, in order for any complaint made by a service user to be fully investigated.¹³⁹ A written copy of the complaints procedure must be furnished to

¹³⁴ Section 23(1) of the *Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003*.

¹³⁵ Regulation 5(1),(2) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹³⁶ Regulation 6(1)(b) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹³⁷ Regulation 14(a),(b),(c) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹³⁸ Regulation 14(e) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹³⁹ Regulation 22(1) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

the service user, or to their representative, upon request.¹⁴⁰ The registered person must establish and maintain a system for evaluating the quality of the services.¹⁴¹ These regulations seek to ensure that the service user is protected within the provision of service, and that they are encouraged to participate in their care plan

2.58 The regulations make requirements as to the suitability of all staff involved in the provision of domiciliary care. Specific measures are set down in relation to the fitness of registered providers, registered managers and domiciliary care staff in general. All staff must be of good character and integrity, must be mentally and physically fit and must satisfy certain prescribed criteria.¹⁴² They must have the requisite skills and experience to perform their job to a certain minimum standard. The registered person must also ensure that the agency is always staffed with a sufficient number of suitably qualified care workers, so that the agency can fulfil its obligations.¹⁴³ In this regard, the registered person must ensure that each employee of the agency receives training and appraisal, and is assisted in pursuing further training or qualifications.¹⁴⁴

(b) Domiciliary Care Agencies: Minimum Standards

2.59 The Northern Ireland Department of Health may prepare and publish statements of minimum standards in respect of care providers.¹⁴⁵ Thus the Domiciliary Care Agencies: Minimum Standards were published in July 2008. These standards apply to both independent and statutory domiciliary care agencies, but they do not apply to agencies which operate as employment agencies. These standards give effect to the regulations and are used by the RQIA, when it is determining the extent to which an agency has met the regulatory requirements. These standards focus on the quality of care service

¹⁴⁰ Regulation 22(3) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹⁴¹ Regulation 23 of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹⁴² Regulations 8(3), 10(2), 13 of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹⁴³ Regulation 16 of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹⁴⁴ Regulation 16(2)(a),(b) of the *Domiciliary Care Agencies Regulations (Northern Ireland) 2007*.

¹⁴⁵ Section 38(1) of the *Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003*.

users receive and the management of the domiciliary care agency. The standards cover key areas of service provision and are applicable across various settings. The standards are measurable through self-assessment and inspection by the RQIA.

2.60 A major focus of these standards is promoting quality care that is service user centred.¹⁴⁶ The aim of the standards is to ensure that the care service is delivered in a manner which respects the service user as an individual and also empowers the service user, by encouraging their participation in the provision of the service.¹⁴⁷ Records must be kept of all feedback from service users and action must be taken to address any issues that they may raise.¹⁴⁸ In order to ensure that service users are encouraged to participate in their care, service providers must supply prospective service users with a service user's guide, which contains relevant information about the agency and the general terms and conditions for receipt of the agency's services.¹⁴⁹ Like standards in other jurisdictions, the Northern Irish standards provide that each service user must be provided with a written individual service agreement before the commencement of the service. This is effectively a contract; it must specify the details of the care service that is to be provided and the method as to how it is to be provided. The agreement must also contain the terms and conditions of the service provision and any arrangements that are agreed in relation to any financial transactions.¹⁵⁰ The standards require that the agreement is regularly monitored, reviewed and up-dated accordingly.¹⁵¹ The standards stipulate that the agency supplying the domiciliary care must have in place sufficient arrangements to ensure that care workers can manage medicines in a safe and secure manner. The service user is encouraged to administer their own medication but, where this is not possible, the care plan must take account of what procedures are to be followed where assistance is provided for the administration of medicines.¹⁵²

2.61 The standards make specific provision with regard to the management of the domiciliary care agency. The agencies are required to have

¹⁴⁶ Department of Health, Social Services and Public Safety *Domiciliary Care Agencies: Minimum Standards* at 9.

¹⁴⁷ Standard 1.2 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁴⁸ Standard 1.3 and 1.4 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁴⁹ Standard 2.2 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁰ Standard 4.2 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵¹ Standard 4.3 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵² Standard 7 of the *Domiciliary Care Agencies: Minimum Standards*.

effective management systems in place that support and promote the delivery of quality care services.¹⁵³ The purpose of these requirements is to ensure that the business of the agency operates smoothly, so that the service user receives the best level of care. In this regard, agencies are required to have a defined management structure in place that identifies the lines of accountability. The registered person is required to monitor the quality of services in accordance with the agency's written procedures, and is also required to complete a monitoring report on a monthly basis.¹⁵⁴ Agencies must also have clear systems in place for record keeping in accordance with legislative requirements.¹⁵⁵ The standards also make certain provisions in relation to the recruitment and training of staff. Potential staff must satisfy specific criteria before an offer of employment will be made.¹⁵⁶ The registered manager must ensure that all newly appointed staff have undertaken training that fulfils mandatory training requirements¹⁵⁷ and all staff must be monitored and their performances appraised. The aim of this is to promote the delivery of quality care to service users.¹⁵⁸ The standards make specific provision for the protection of service users from abuse.¹⁵⁹ Procedures for protecting vulnerable adults must be included in the induction programme for staff.¹⁶⁰ Care workers are required to complete training so that they are informed about abuse of vulnerable adults and know the indicators of abuse.¹⁶¹ The standards require that all suspected, alleged or actual incidents of abuse be reported to the relevant agencies in accordance with the procedures developed by the agencies.¹⁶² Agencies are required to have an adequate complaints system in place to deal with any issue that a service user may have. This ensures that all complaints are taken seriously and are dealt with effectively.¹⁶³

¹⁵³ Standard 8 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁴ Standard 8.11 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁵ Standard 10 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁶ Standard 11.2 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁷ Standard 12.2 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁸ Standard 13 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁵⁹ Standard 14 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁶⁰ Standard 14.3 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁶¹ Standard 14.4 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁶² Standard 14.6 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁶³ Standard 15 of the *Domiciliary Care Agencies: Minimum Standards*.

2.62 The Northern Irish standards also make detailed provision requiring the registration of domiciliary care agencies, though there are no standards setting out specific requirements, agencies are required to show that they are meeting certain requirements, prior to agencies and persons being registered. These requirements include demonstrating that the registered person and the registered manager are fit to perform their duties.¹⁶⁴

(5) Conclusion

2.63 The regulations and standards set down in England in relation to domiciliary care agencies are comprehensive, and form the blueprints for which other jurisdictions have published their own regulations and standards. The English standards are user focused and seek to ensure that the health and well-being of the service user is supported by every aspect of the care service. The standards flesh out the regulations and set out very clear processes and procedures that domiciliary care agencies must follow in order to meet the regulations. The regulations and the standards achieve their objectives of protecting the service user and promoting their independence.

2.64 The Welsh regulations and standards, by and large, mimic the English regulations and standards. There is only a slight variation in the Welsh provisions in the use of certain phrases or words, but the resulting meaning or intention of the provisions is the same as the English provisions.

2.65 The focus of the Scottish standards is very much on the service user as an individual. The standards seek to ensure that the social, cultural and spiritual beliefs of the individual are respected.¹⁶⁵ While the Scottish standards do promote the service user's dignity and privacy, they make no provision to protect the service user from elder abuse. Unlike the English domiciliary standards, the Scottish standards do not make provision for the organisation of the business.

2.66 The language employed in the Scottish standards focuses on the outcome of the standard, rather than the process by which the outcome is achieved. The language is user-focused, and makes statements such as:

“You are confident that the service will get in touch with the healthcare services if you need them to.”¹⁶⁶

While this use of language is useful for assisting service users in determining what they can expect from the service, it makes it difficult for service providers

¹⁶⁴ Standard 2 of the *Domiciliary Care Agencies: Minimum Standards*.

¹⁶⁵ Standard 5 of the *National Care Standards: Care at Home*.

¹⁶⁶ Standard 7 of the *National Care Standards: Care at Home*.

to know exactly what they must do to comply with the standards. The standards do not state explicitly how service providers are to meet the requirements. The English standards are far more detailed than the Scottish standards and they inform service providers of the exact measures that they must take to comply with the standards. This makes it easier for service providers in England to identify what they must do to meet the standards.

2.67 The Northern Irish standards repeat much of what is set out in the English and Welsh standards. As with those standards, the Northern Irish standards are user focused and aim to ensure that the care service is delivered in a manner which respects the individuality of the service user, and encourages the individual to participate in all aspects of the care process.

C Standards in Ireland for other sectors

2.68 While the Minister for Health and Children has the legislative authority to draw up regulations for the purpose of ensuring proper standards in relation to designated centres, the section conferring this power has not yet been commenced.¹⁶⁷ Under this section, the Minister could make regulations in relation to the maintenance, care, welfare and well-being of persons resident in the designated centre. Such regulations could also make provision in relation to the care environment and the staffing and management of the organisation.¹⁶⁸ HIQA has used its authority to publish standards in relation to certain aspects of the care service.¹⁶⁹ It is the intention of HIQA that these standards be used when an inspection of a service is being carried out. HIQA states that some of the standards are linked to regulations, particularly in relation to the standard that requires residential care providers to register. Many of the standards are not linked to regulations, but are designed to encourage continuous improvement.

2.69 It is important to look at standards already drawn up by HIQA for care services other than domiciliary care services, in order to determine the issues which the Irish Authority deems important. In this respect, this section shall examine the *National Quality Standards for Residential Care Settings for Older People in Ireland* and the *National Quality Standards: Residential Services for People with Disabilities*, in order to establish the common themes and issues that the two sets of standards deal with.

2.70 Under the *National Quality Standards for Residential Care Settings for Older People in Ireland*, HIQA set down a broad range of standards which cater for every aspect of the older person's residential care. The standards are comprehensive and set down what a person can expect in relation to each element of their residential care. The standards aim to protect the rights¹⁷⁰ and

¹⁶⁷ Section 101 of the *Health Act 2007* empowers the Minister for Health and Children to make regulations.

¹⁶⁸ Section 101(2) of the *Health Act 2007*.

¹⁶⁹ Health Information and Quality Authority *National Quality Standards for Residential Care Settings for Older People in Ireland (2009)* and Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities (2009)*.

¹⁷⁰ Standards 4 and 5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

quality of life¹⁷¹ of the individual, as well as providing requirements for the staffing and governance of the service. The standards are “person-centred” and encourage the participation of the individual in every aspect of his or her care.¹⁷²

2.71 Both sets of standards are intended to ensure that those who live in residential centres receive a good quality and safe service. The standards are designed to safeguard the rights and interests of older people and people with disabilities in residential centres, by seeking to enhance their quality of life. Both sets of standards flow from a human rights perspective. The standards adopt a person-centred approach to the provision of services, requiring that the service is designed in a manner that reflects the service user’s needs, preferences and priorities.

2.72 The standards are broken into themes, and these themes are organised below in a specific manner. In a note within in the *National Quality Standards: Residential Services for People with Disabilities*, HIQA stated that while the standards were not set out in order of priority, the sequence in which they occurred was the outcome of careful consideration, reflecting the views of the service user members of the Standards Advisory Group.¹⁷³

(1) Quality of life

2.73 The concept of quality of life is central to both sets of standards. The standards seek to ensure that service users receive a standard of care that respects them as individuals and encourages them to participate in the decision-making process. Both sets of standards make provision relating to the service users autonomy and provides that each individual be encouraged to exercise choice and control over his or her life.¹⁷⁴ The service provider must encourage each individual to maintain and maximize his or her independence.

¹⁷¹ Standard 4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁷² Standard 2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁷³ *National Quality Standards: Residential Services for People with Disabilities* at 11.

¹⁷⁴ Standard 1 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 17 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

2.74 Service providers must ensure that the care being provided respects the previous routines, expectations and preferences of the service user.¹⁷⁵ This promotes a sense of safety and security for the individual through regularity and predictability. The individual's social, religious and cultural beliefs must be accommodated within the routines of daily living.¹⁷⁶ The standards also require that the preferences of the individual are taken into account in relation to meals and mealtimes.¹⁷⁷ The service user is encouraged to maintain his or her personal relationships and the service provider must facilitate this by ensuring that no restrictions are placed on visitors, except in accordance with the individual's wishes.¹⁷⁸

2.75 Both sets of standards require that the individual's privacy and dignity are respected.¹⁷⁹ However, the *National Quality Standards: Residential Services for People with Disabilities* classify the provision relating to privacy and dignity under the "Quality of Life" section, whereas the *National Quality Standards for Residential Care Settings for Older People in Ireland* refer to the service users right to privacy and dignity. The provisions set down in relation to this right to privacy and dignity are comprehensive, and more extensive than the provisions set down in the *National Quality Standards: Residential Services for People with Disabilities*. Staff are required to demonstrate their respect for the individual's privacy and dignity in every aspect of their interaction. A list of specific occasions when care providers must have particular regard for the individual's privacy and dignity, such as dressing and undressing, is set out. Privacy and dignity are central to promoting the service user as an individual and as a

¹⁷⁵ Standard 3 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 18 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁷⁶ Standard 3.5 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 18.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁷⁷ Standard 3.6 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 19 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁷⁸ Standard 4 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 20 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁷⁹ Standard 2 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

human being. Perhaps it makes a stronger statement to consider privacy and dignity under the “Rights” section rather than under the “Quality of Life” section.

(2) Staffing

2.76 Both sets of standards acknowledge that staff working with service users have a significant impact on the quality of life of those individuals. Thus, both sets of standards make detailed provision in relation to the recruitment, training and supervision of staff. The purpose of these provisions is to ensure that service users receive their care from those best suited to provide it, and that they are protected from abuse. All staff must be recruited in accordance with best practice, including the provision of adequate references and proof of qualifications. They must also complete a vetting process, designed to protect vulnerable service users.¹⁸⁰

2.77 Staff are provided with a continuing training and development programme to ensure that they maintain their competence.¹⁸¹ Service providers must ensure that the service is staffed by a sufficient number of qualified staff at all times.¹⁸² The Draft Standards further require that all staff are aware of and adhere to key service policies and procedures including safe care and medication management.¹⁸³

(3) Protection

2.78 Protecting the health and well-being of the service user is one of the main priorities of both sets of standards. Both standards require that each service user is safeguarded and protected from all forms of abuse.¹⁸⁴ The standards require that the service providers have policies in relation to the

¹⁸⁰ Standard 5 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 22 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸¹ Standard 5.12 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 24.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸² Standards 5.9 and 5.10 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 23.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸³ Standard 5.14 of the *National Quality Standards: Residential Services for People with Disabilities*.

¹⁸⁴ Standard 6 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 8 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

prevention, detection and response to abuse.¹⁸⁵ Staff must also receive induction and on-going training in prevention, detection and reporting of abuse, in identifying abuse and understanding the particular vulnerability of service users to abuse.¹⁸⁶

2.79 Specific provision is made in both sets of standards for the financial protection of service users.¹⁸⁷ Procedures must be put in place so that a record of all financial transactions carried out by staff on behalf of the individual is maintained.¹⁸⁸ The service provider must provide facilities for the safe storage of the service user's money and valuables.¹⁸⁹ The aim of these provisions is to safeguard the service user and their finances from all forms of abuse and exploitation.

(4) Health and development

2.80 As the standards cater for the specific needs of different groups of people in different situations, they will not approach the same themes from the same perspectives. Both standards require an individual plan to be drawn up in respect of each service user and in accordance with his/her wishes.¹⁹⁰ The plan must be reviewed and updated regularly in order to ensure that the care being

¹⁸⁵ Standard 6.15 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 8.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸⁶ Standard 6.18 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 8.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸⁷ Standard 7 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 9 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸⁸ Standard 7.4 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 9.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁸⁹ Standard 7.6 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 9.5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁹⁰ Standard 8 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 11 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

delivered continues to meet the individual's needs.¹⁹¹ The standards also make detailed provision in relation to the health needs of individuals.¹⁹² The Draft Standards provide that the service user must be encouraged to live healthily and to take responsibility for their own health.¹⁹³ In this regard the service provider must ensure that the service user has access to health education, information and practical support.¹⁹⁴

2.81 In the *National Quality Standards for Residential Care Settings for Older People in Ireland*, service providers are required to have policies and practices that promote the health and well-being of the service user.¹⁹⁵ These policies and procedures must be based on current best practice and developed and reviewed annually.¹⁹⁶ Both standards make specific provision in relation to the management of a service user's medication.¹⁹⁷ Where appropriate, each individual is encouraged to be responsible for their own medication.¹⁹⁸ Service providers are required to have policies and procedures in place in relation to medication management that complies with legislative and regulatory

¹⁹¹ Standard 8.10 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 11.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁹² Standard 9 of the *National Quality Standards: Residential Services for People with Disabilities* and standards 12 and 13 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁹³ Standard 9.1 of the *National Quality Standards: Residential Services for People with Disabilities*.

¹⁹⁴ Standard 9.2 of the *National Quality Standards: Residential Services for People with Disabilities*.

¹⁹⁵ Standard 12 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁹⁶ Standard 13.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁹⁷ Standard 9.12-9.14 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 14 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁹⁸ Standard 9.12 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 14.9 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

requirements.¹⁹⁹ The individual's medication is monitored and reviewed by his or her medical practitioner.²⁰⁰

2.82 The aim of these standards is to maintain the well-being of the service user by ensuring that they receive suitable medication. Maintaining the independence of the individual is also a central aim of these specific standards.

2.83 The *National Quality Standards for Residential Care Settings for Older People in Ireland* also make provision for end of life care,²⁰¹ something which the *National Quality Standards: Residential Services for People with Disabilities* do not. This is an area that any domiciliary care standards will have to examine and make provision for. The standards require that each service user must continue to receive care at the end of their lives, which meets their own personal needs in terms of physical, emotional and spiritual needs. The end of life care must respect the service user's dignity and autonomy. The standards require that the service user's wishes and choices regarding end of life care be discussed and documented and, in as far as is possible, implemented and reviewed regularly with the resident.²⁰² Staff must be trained in end of life care²⁰³ and the residential care setting must have the appropriate facilities to cater for end of life care.²⁰⁴

(5) Rights

2.84 Both sets of standards make special provision regarding the rights of service users as citizens first. Each service user has the right to have access to

¹⁹⁹ Standard 9.13 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 14.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰⁰ Standard 9.14 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 15.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰¹ Standard 16 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰² Standard 16.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰³ Standard 16.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰⁴ Standard 16.5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

information that will assist him/her in informed decision making.²⁰⁵ Such information must include the services and facilities provided an outline of the complaints procedure and details of those in charge. The *National Quality Standards for Residential Care Settings for Older People in Ireland* provide that the rights of service users to consult and participate in the organisation of the residential care setting must be reflected in all policies and procedure. The service provider is required to establish an in-house residents' representative group for feedback, consultation and improvement on all matters affecting the residents.²⁰⁶

2.85 One of the most important rights of service users is the right to consent to treatment.²⁰⁷ In both standards, service users are presumed to be capable of making informed decisions.²⁰⁸ Service providers must have a policy in place that ensures that the informed consent is obtained from the individual.²⁰⁹ The service user must be provided with clear explanations in order to assist him/her in making an informed decision.²¹⁰ The wishes and choices of the service user in relation to treatment and care must be documented and should be reviewed regularly.²¹¹

²⁰⁵ Standards 10 and 11 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰⁶ Standard 2.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰⁷ Standard 11 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰⁸ Standard 11.1 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 3.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁰⁹ Standard 11.6 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 3.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹⁰ Standard 11.4 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 3.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹¹ Standard 11.2 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 3.6 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

2.86 Service providers are required to listen to and act upon any complaint made by an individual service user or his family, advocate or representative.²¹² The person-in-charge must ensure that there is a clear complaints procedure in place that details how a complaint can be made and to whom, and the stages and timescales of the complaints process amongst other details.²¹³ A record of all complaints should be maintained and should include details of investigations made into the complaint as well as and any action taken.²¹⁴

2.87 Each service user is to be provided with an agreement, or contract, that they and the registered provider must both sign.²¹⁵ This agreement should specify the terms and conditions of the service to be provided to the individual, and the rights, obligations and liability of the individual and of the registered provider. The *National Quality Standards for Residential Care Settings for Older People in Ireland* require the details of the financial arrangement for the service to be chronicled in this contract. The *National Quality Standards: Residential Services for People with Disabilities* do not require this financial arrangement to be included in the agreement. The provision for this contract within a domiciliary care arrangement shall be discussed in more detail in Chapter 3.

(6) Care environment

2.88 The standards seek to ensure that the care that service users receive is provided in an environment designed to ensure a good quality of life. Specific requirements as to the physical environment are set out in a detailed list of criteria. These criteria set out extensive requirements in relation to physical characteristics of the care home.²¹⁶ The standards also require that the health and safety of each service user is promoted and protected in order to safeguard

²¹² Standard 14 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 6 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹³ Standard 14.4 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 6.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹⁴ Standard 14.6 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 6.5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹⁵ Standard 13.10 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 7 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹⁶ Standard 25 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

the individual's right to a good quality of life.²¹⁷ The person in charge must ensure that there are proper health and safety practices in place and that all staff are educated and trained in all aspects of health and safety.

(7) Governance and management

2.89 Both sets of standards set out requirements in relation to the governance and management of organisations providing the care services. The standards require that the care services are managed by someone competent and appropriately qualified and experienced.²¹⁸ The services are to be governed in a manner that meets the needs of each individual.²¹⁹ Each service provider is required to ensure that there is a mission statement in place and that appropriate policies are communicated to all parties.²²⁰ The person-in-charge must fulfil all duties prescribed in the regulations and standards, and all legislative requirements. The standards require that there is an internal management structure appropriate to the size and purpose of the service that identifies the lines of authority and accountability.²²¹

2.90 The person in charge must ensure that all policies, procedures and practices are regularly reviewed and updated. The person in charge of a residential care service must also ensure that the quality of care and experience of the residents are monitored and developed on an ongoing basis.²²² The

²¹⁷ Standard 16 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 26 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹⁸ Standard 17.8 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 27 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²¹⁹ Standard 17.3 of the *National Quality Standards: Residential Services for People with Disabilities*.

²²⁰ Standard 17.5 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 28 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²²¹ Standard 17.7 of the *National Quality Standards: Residential Services for People with Disabilities* and Standard 29.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²²² Standard 30 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

standards further seek to safeguard the service user by requiring that appropriate record-keeping policies and procedures be followed.²²³

(8) Conclusion

2.91 Both the National Quality Standards for *Residential Care Settings for Older People in Ireland* and the *National Quality Standards: Residential Settings for People with Disabilities* make comprehensive provisions, the aim of which is to protect service users through the regulation and monitoring of the care services. Both sets of standards address common issue and any standards which could be drawn up in the future for the domiciliary care sector should take these issues into consideration. It is also worth noting that an Expert Advisory Group and Governance Group on Services for Older People drew up a set of National Quality Home Care Support Guidelines in October 2008. These Guidelines have not yet been fully approved for operation and implementation, and are currently progressing through the HSE. If they are approved by the HSE, they will be sent to the Department of Health and Children, for further approval and then they will be finally published. The Guidelines seek to address the various issues posed by the lack of regulation for a rapidly expanding domiciliary care sector. The Guidelines look specifically at the rights of older people, the need to protect the health and social care needs of older people and also the staffing, management and governance of domiciliary care providers.

D Conclusion

2.92 Due to the unique set up in which domiciliary care is provided, any standards will need to be tailored specifically for domiciliary care and cannot be merely transposed from standards drawn up by HIQA for other areas of the care sector. As there are no previous or current regulations or standards in place in Ireland for domiciliary care agencies, the regulations and standards drawn up by other jurisdictions is useful. Standards from other jurisdictions focus on protecting the service user and their property, by requiring that policies and procedures be drawn up in respect of the provision of care and in respect of all financial transactions. These standards also require that procedures are in place to ensure the proper organisation and management of the service, so that service users can rely on a well organised service. It is important to note that where other jurisdictions have published standards for the domiciliary care sector, these have been supported by domiciliary care Regulations.

²²³ Standard 19 of the *National Quality Standards: Residential Services for People with Disabilities* and standard 32 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

2.93 The standards set down in Ireland for other elements of the care sector should, in the Commission's view, be suitably adapted to the domiciliary care setting. The standards already in place in Ireland highlight different categories in which standards are necessary in order to ensure that care is provided in a manner which promotes the well-being and independence of the service user. Any standards for the domiciliary care sector should incorporate each of the categories identified above, and should also be user-focused. Such standards must take into account the different situations that arises in a domiciliary care arrangement, in particular the fact that the service is provided within the service user's own home. The standards in relation to protection may need to be stronger than the protection standards afforded to residents of care homes. The contractual arrangement between the service user and the service provider must also be considered, and the various rights, responsibilities and obligations of each party to the contract should be explicitly set out.²²⁴ All standards should have as their objective the promotion of the quality of care, the protection of the health and well-being of the individual and should encourage the participation of the individual in the entire care process. There are some areas which are covered by the two sets of standards, which may be of less relevance to any standards for domiciliary care providers, for example the standards on the care environment. In a domiciliary care arrangement, the care is provided in a person's own home, and so it may be considered to be too onerous to set down standards requiring the care recipient to adapt their home in order to comply with the standards.

2.94 The Commission has, in this respect come to the clear conclusion that the standards it proposes for domiciliary care should be specifically tailored for the domiciliary care setting, building on existing HIQA standards for the residential care setting. The Commission also considers that the proposed standards should ensure that domiciliary care is provided in a manner that promotes the well-being and independence of the service user in their own home.

2.95 *The Commission provisionally recommends that HIQA publish standards which should be specifically tailored for the domiciliary care setting, building on existing HIQA standards for the residential care setting. The Commission also provisionally recommends that the proposed standards should ensure that domiciliary care is provided in a manner that promotes the well-being and independence of the service user in their own home.*

²²⁴ This is an issue that will be considered in more detail in Chapter 3 and 4.

CHAPTER 3 CARE CONTRACT

A Introduction

3.01 The delivery of home care services raises various issues relating to the safety and autonomy of the recipient of care (the “service user”). Due to the inherent vulnerability of people who enter into agreements for the provision of personal care in their home, detailed measures need to be taken to protect these people. There is a need for the specific details of the provision of home care as agreed between the parties to be formally recorded. By documenting the agreed terms and conditions of the provision of care, both the service user and the service provider are aware of their respective rights and responsibilities. Part B examines the concept of the care contract, which will be informed by public standards. Part C discusses various issues which could form the core provisions of the care contract. In particular, this section shall examine the competency of the service provider, the terms and conditions of the provision of care, the requirement for financial transparency of the arrangement and the various rights and responsibilities of both parties. Part D concludes with a summary of the chapter.

B Care contract and public standards

3.02 The very nature of the provision of home care is such that the recipients of the service are automatically placed in a vulnerable position, as it involves someone entering their own home and providing them with a service that they need. The fact that an individual needs some form of care at home highlights their vulnerability and also the level of trust that they must place in the person or agency providing the service. The need for domiciliary care can arise where a person’s ability to care for themselves unaided gradually or rapidly diminishes. People who receive care at home may not always be able to defend themselves where they are suffering abuse or neglect. Of course there are many recipients of home care that will be able to represent themselves. However, in order to protect all individuals who receive domiciliary care, there should be a type of care contract, which could be used to by individuals or someone on their behalf to set out the various terms and conditions of the provision of care arrangement.

3.03 This contract would be informed by the proposed standards to be drawn up by HIQA. As such, parties to the care contract would be required to meet whatever standards HIQA sets down. This would ensure that no individual or agency would be able to provide a domiciliary care service unless they meet the HIQA standards. In turn, this would protect the individual care recipient by ensuring that the service being provided was of a certain standard and quality.

3.04 The care contract may focus on the competence of the service provider to provide the appropriate services to meet the needs of the individual. The care contract may also refer to the specific terms and conditions of the arrangement for the provision of care. These terms and conditions would set out a minimum standard, which the service provider would be unable to contract out of. The various policies and procedures that the service provider has in place in relation to the protection of the service recipient should also be documented in the care contract. This care contract would act as a guide for both care recipients and domiciliary care providers, by identifying what services are to be provided and how they are to be provided.

C Core provisions of the care contract

3.05 As discussed above, the care contract should set out certain minimum requirements which the service provider must meet and which it cannot contract out of. This section shall examine the issues which could make up the core contractual provisions, by identifying the components which should make up the core provisions of the contract. The contract should also ensure that the needs of the service user are met, that their autonomy and independence are respected, and that he or she is protected from financial abuse. The care contract will look at the minimum competence level below which the service provider must not fall. The code of competence should be set out in the standards. The core provisions of the care contract should also refer to the terms and conditions of the provision of care. The policies and procedures that a service provider has in place for protecting the service recipient should also be detailed in the care contract.

3.06 Under HIQA's *National Quality Standards for Residential Care Settings for Older People in Ireland*, the registered provider of the residential care home must supply the service user with a contract within a month of their admission.¹ The *National Quality Standards: Residential Services for People with Disabilities* make no reference to a particular time-frame in which the service provider must provide the service user with the individual service

¹ Standard 7.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

agreement.² In England, the standards require that the agency providing the care must issue a written contract to the service user within 7 days of the commencement of the service.³ The standards drawn up in Scotland, do not specify any particular deadline in terms of when the written agreement must be issued to the service user, but it does provide that the written agreement must include the date that the agreement was made, as well as the date on which the service starts. This would suggest that the agreement must be issued to the service user prior to the commencement of the service.⁴ In Wales the standards make an explicit requirement for the agency to issue a statement of terms and conditions prior to the commencement of the service.⁵

(1) Competence of service provider

3.07 Where a person contracts for the provision of home care, he or she must be able to ascertain whether or not the service provider has the capacity to deliver the service competently. The delivery of effective personal care services to people living in their own home requires a clear infrastructure which identifies each stage of the process of service delivery and provides policies and procedures which supports practice.⁶ The *Sale of Goods and Supply of Services Act 1980* provides that where a person enters into a contract for the provision of any service, he or she can expect that the service provider has the requisite skill and experience to deliver the service competently.⁷ Where a person is entering into a contract for the provision of home care, it is even more important to ensure that the service provider can provide the services competently. In order to ensure that vulnerable people are adequately protected when they enter into a contract for the provision of home care, the care contract should make specific requirements regarding the competency of service providers to provide services. This would help to protect the service user from abuse by ensuring that the services provided are provided with due care and skill. Many other jurisdictions require that specific provisions be set out in these

² Standard 13.11 of the *National Quality Standards for Residential Care Settings for People with Disabilities*.

³ Standard 4.1 of the *Domiciliary Care – National Minimum Standards*.

⁴ Standard 2.2 of the *National Care Standards: Care at Home*.

⁵ Standard 5.1 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

⁶ Department of Health *Domiciliary Care – National Minimum Standards* at 35, available at www.dh.gov.uk.

⁷ Section 39(a)-(b) of the *Sale of Goods and Supply of Services Act 1980*.

contracts in order to ensure the quality of the service that is being supplied, this is discussed below.

(a) Quality assurance

3.08 The care contract should seek to ensure the competence of the service provider by making certain requirements with regard to the quality of the service being provided. This will ensure that the service user is fully aware of the degree of skill and experience of the service provider has. The service user can thus make an informed decision about whether the service provider will be capable of meeting his or her needs.

3.09 The National Quality Standards for Residential Care Settings for Older People make certain requirements in relation to the skill and qualification of staff. The purpose of those requirements is to ensure that the care services are delivered in accordance with the standards and the needs of the resident are addressed by people with the requisite level of skill and experience.⁸ However, the contract between the registered provider of the residential care setting and the resident does not stipulate that these requirements must be included in the care contract.⁹ It is useful to examine what requirements are set out in other jurisdictions with regard to the quality assurance of home care services. The England, the *Domiciliary Care Agencies Regulations 2002* state that the registered person should ensure that all domiciliary care workers employed by the agency are of good character and have the requisite skills and experience necessary to fulfil the role for which they were employed.¹⁰ In giving effect to these regulations, the English Domiciliary Care - National Minimum Standards require the contract to set out the processes that the service provider has established for ensuring that the quality of the home care service is of a certain standard.¹¹ By stipulating that the home care worker has a certain level of qualification, skill and experience, the regulations and standards seek to ensure that the quality of the service being provided is of a certain level. Standards in other jurisdictions simply require that service providers have

⁸ Standard 23 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁹ Standard 7 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁰ Regulation 12(a)-(b) of the *Domiciliary Care Agencies Regulations 2002*.

¹¹ Standard 4(2) of the *Domiciliary Care – National Minimum Standards*.

quality assurance processes, but do not stipulate that these processes should be included in the contract as part of the terms and conditions.¹²

3.10 Including such requirements in the care contract would allow the service user to establish the competency of the service provider enabling them to determine if the service provider will be able to meet their needs. In order to offer service users the highest level of protection, measures must be taken to ensure that the service provider is capable of providing the service required to a certain standard. The inclusion of a specific term regarding the quality of the home care workers and the agency itself, would be a high form of protection for the service user.

(b) Monitoring and supervision of staff

3.11 While it is important to ensure that all home care workers have the requisite qualifications, skill and experience, it is also important to ensure that all home care workers are adequately monitored and supervised in the performance of their jobs. Staff may have the relevant skills and experience, but due to the vulnerable position of people receiving home care, further monitoring and supervising mechanisms would offer even greater protection and even greater quality assurance.

3.12 The *National Quality Standards for Residential Care Settings for Older People in Ireland* make only basic provisions in relation to the monitoring and supervision of staff.¹³ Under these standards, employers are required to ensure that all staff receive induction and continued professional development and appropriate supervision throughout their employment. Residential care providers are required to assess the competency and skills of all staff in order to determine if they need more training.¹⁴ The Standards do not require such provisions to be included in the contract. The recently published *National Quality Standards for Residential Services for People with Disabilities* do not provide extensive requirements in terms of the monitoring and supervision of

¹² Standard 4 of the *Scottish National Care Standards – Care at Home* provides that the home care is provided by management and care staff who have the requisite skills and competence to carry out the tasks required by the individual service user. The Standards do not require the contract of care to take account of such requirements. Standard 27 of the *National Minimum Standards for Domiciliary Care Agencies in Wales* makes a similar requirement, but the Standards do not require that the processes of assuring the quality of the home care service be included in the contract of care.

¹³ Standard 24 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

¹⁴ *Ibid* at standard 24.2.

staff. The person in charge must ensure that there are systems in place for monitoring the quality of the service as experienced by the individual.¹⁵ There is no provision in these standards which requires the individual service agreement to make provision for the monitoring and supervision of staff. HIQA has the authority to monitor healthcare providers to ensure that the national standards are being met. By amending section 8(1)(b) of the *Health Act 2007* to include the home care setting, HIQA's authority to monitor healthcare providers could be extended to cover home care agencies.¹⁶

3.13 In England, extensive requirements with regard to the supervision of home care workers are placed on domiciliary care agencies.¹⁷ Under the Regulations, domiciliary care agencies are required to ensure that all staff members receive appropriate training and appraisal. Upon such appraisal, the agency is required to take any measures necessary to address any unsatisfactory aspect of the care worker's performance. The Standards specify that these arrangements for monitoring and supervising staff must be included as part of the terms and conditions of the care contract.¹⁸ There are similar requirements provided for under the *Domiciliary Care Agencies (Wales) Regulations 2004*.¹⁹ The Welsh standards specifically require the terms and conditions of the contract to specify the arrangements in place for monitoring and supervising staff.²⁰

3.14 Although the standards of care that have been drawn up in Ireland do not specifically require the care contract to set out the monitoring and supervision procedures, other jurisdictions do such monitoring and the implementation of supervision arrangements. By requiring home care agencies to set out the procedures for the monitoring and supervision of staff, the care contract would add to the protection of the service user, by ensuring that each home care worker is being supervised and assessed on a regular basis. This not only protects the service user, but also the employee and the agency. By

¹⁵ Standard 17.16 of the *National Quality Standards for Residential Services for People with Disabilities*.

¹⁶ This is discussed in Chapter 1.

¹⁷ Regulation 15(2)(a) and 15(3) of the *Domiciliary Care Agencies Regulations 2002*.

¹⁸ Standard 4.2 of the *Domiciliary Care – National Minimum Standards*.

¹⁹ Regulation 16(2)(a) and 16(3) of the *Domiciliary Care Agencies (Wales) Regulations 2004*.

²⁰ Standard 5(2) and standard 13 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

ensuring that regular appraisals are carried out, the agency can identify if any employee is having difficulty performing their job, and may offer assistance or further training to remedy the situation. Regular appraisals also ensure that agencies can adapt to any change in the condition of the service user.

(2) Provision of care

3.15 It is important that both parties are aware of what exactly they are contracting for. In any contract for the supply of a service, the terms and conditions of the provision of the service are set out in detail. Where a person enters a contract for the supply of a home care service, the specific terms and conditions for the supply of the service need to be agreed and formally recorded. This will ensure that both parties are fully informed of their responsibilities. In contracts for the supply of home care, it is also important that the contract records what services are not covered by the contract and the level of flexibility involved in the provision of the service.

(a) Terms and conditions of care

3.16 There is no doubt that the terms and conditions of the provision of care need to be discussed and agreed between the service user and the service provider. The changing nature of the service user's needs and circumstances should be reflected in the terms and conditions of the provision of care. The terms and conditions of care should protect the autonomy and independence of the service user and encourage their participation in the delivery of care as far as possible. A key issue is whether the terms and conditions of the provision of care specific to the individual service user are best dealt with under the care contract or under a type of service user's care plan, the terms of which would be established under national standards.

3.17 It is useful to examine how HIQA's National Quality Standards for Residential Care Settings for Older People treat the terms and conditions of the provision of care. The Standards require that the contract for services sets out the overall care and services covered by the fee being charged.²¹ Additionally the Standards also require that the contract takes account of any additional health, personal and social care services that do not form part of the agreed services.²² The Standards do not require the contract to specify any further specific details regarding the provision of care. However, they do necessitate that the resident's care plan sets out in detail how the health, personal and

²¹ Standard 7.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²² Standard 7.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

social care needs of the resident are to be met by the staff.²³ All residents, including those with a cognitive impairment, must be encouraged to participate in the formulation of the care plan.²⁴ The care plan must be reviewed and updated regularly, to reflect the changing needs and circumstances of the resident.²⁵

3.18 Regulations and standards in other jurisdictions set down similar requirements with regard to the terms and conditions of the provision of care. Under the English Regulations, the general terms and conditions of the provision of care by the service provider, and the amount and method of payment, must be set out in a service user's guide.²⁶ This service user's guide provides the service user and potential service users with information so that he or she can determine whether the service provider in question has the capacity to meet his or her specific needs. Furthermore, a service user plan must be drawn up by the registered person of the agency in consultation with the service user.²⁷ This service user plan must set out the specific terms and conditions of home care that the individual service user is to receive. This form of individual care plan ensures that the specific needs of the service user are met.

3.19 The Domiciliary Care – National Minimum Standards go further than HIQA's National Quality Standards for Residential Care Settings for Older People in terms of required terms and conditions of the care contract. Under the Domiciliary Care – National Minimum Standards, the contract must specify the areas of activity which home care or support workers will and will not undertake and the degree of flexibility in the provision of personal care.²⁸ This may include any special needs, medical or otherwise, communication requirements and other specific details of the provision of personal care. For example, if a person needs assistance getting in and out of bed, getting dressed and/or undressed,

²³ Standard 11 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁴ Standard 11.5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁵ Standard 11.6 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

²⁶ Regulation 5 of the *Domiciliary Care Agencies Regulations 2002*.

²⁷ Regulation 14 of the English *Domiciliary Care Agencies Regulations 2002*. The *Domiciliary Care Agencies (Wales) Regulations 2004* make similar provisions with regard to the service user's guide (Regulation 5) and the service user's care plan, called a service delivery plan (Regulation 14).

²⁸ Standard 4.2 of the *Domiciliary Care – National Minimum Standards*.

bathing and/or using the toilet. By recording these specific aspects of care, the service user knows exactly what services he or she will be receiving, and what services will not be covered by the contract. It should be noted that this requirement for the contract to take account of the specific details of the provision of care is not founded on any regulation in England.²⁹

3.20 *The Commission provisionally recommends that the terms and conditions of the provision of care be agreed and recorded in a care contract, in order to offer the maximum protection to the service user.*

(3) Protection

3.21 People who enter into a contract to receive care in their own homes are in vulnerable positions. They are inviting home care workers into their own homes, and as such need to be given assurances that they will be protected in their own homes, and that their safety will be in no way compromised. Issues such as the entering and leaving the home, and key-holding arrangements are important in the context of protecting service users who receive home care. Another important issue is the handling of the service user's money and personal property. Clear arrangements regarding these issues should be agreed between the parties.

(a) Entering and leaving the property

3.22 The issue of the handling of the service user's property and money is even more important in the context of home care provision, as service users are even more exposed than those in a residential care setting.

3.23 It is important to look at the regulations and standards in place in other jurisdictions, to appreciate how these issues are dealt with in a home care setting. In England, the regulations do not make any specific requirements in relation to entering and leaving the home. However, the Standards provide that the care contract must specifically include details of the arrangements agreed for entering and leaving the home and any key-holding arrangements.³⁰ The Welsh Standards also require that the statement of terms and conditions for the provision of care from an agency must specify the key-holding arrangements, and any other arrangements for accessing the home.³¹

²⁹ The *National Minimum Standards for Domiciliary Care Agencies in Wales* makes a similar requirement, but extends the provision to include "the expectations of the service users." Standard 5.2 of the *National Minimum Standards for Domiciliary Care Agencies in Wales 2004*.

³⁰ Standard 4.2 of the *Domiciliary Care – National Minimum Standards*.

³¹ Standard 5.2 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

3.24 The English Standards go on to set out further requirements in relation to entering and leaving the home.³² These protocols set out specific details including; knocking/ringing a bell; speaking out before entering the home/room; written and signed agreements on key-holding; safe handling of keys; alternative arrangements for entering the home; securing doors and windows and action to take in the case of lost or stolen keys.³³ These comprehensive provisions set out the specific terms and conditions that the contract must set out in relation to accessing the home and key-holding arrangements. The Welsh Standards also make similar provisions to protect the service users and to ensure that they are safe and secure in their own homes, though they do not set out the any specific details that the contract must include.³⁴ Both the English and Welsh standards for domiciliary care agencies make specific requirements in relation to identity cards of staff members.³⁵ These provisions offer further protection to vulnerable people who receive care at home.

3.25 *The Commission provisionally recommends that the care contract should contain specific policies in relation to the entering and leaving of the service recipient's home by the carer.*

(b) Handling of money and personal property

3.26 Due to the private setting in which home care is provided, the care contract should set out more precise details in terms of the handling of a service user's money and property than is required under HIQA's standards for residential care. The Commission previously examined the issue of financial abuse in its *Report on Vulnerable Adults and the Law*. The Commission recommended that, in the case of a person whose capacity was limited or absent, it was appropriate that carers could have a "general authority to act" that is to carry out routine acts for such persons, including in connection with financial matters, where that was in the interest of the adult in question.³⁶ This general authority was included in the Commission's draft Scheme of a Mental Capacity and Guardianship Bill 2008 in the Report and has been incorporated

³² Standard 15 of the *Domiciliary Care – National Minimum Standards*.

³³ Standard 15.2 of the *Domiciliary Care – National Minimum Standards*.

³⁴ Standard 15 of the *Domiciliary Care – National Minimum Standards*.

³⁵ Standard 15.3 of the *Domiciliary Care – National Minimum Standards*, and standard 15.3 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

³⁶ LRC 83-2006, at paragraph 2.88.

into Head 16 of the Government's *Scheme of a Mental Capacity Bill 2008*, published in 2008.³⁷

3.27 The Commission notes that provision for a general authority to act does not apply to all financial arrangements made between a carer and an adult who may be vulnerable. It is therefore, necessary to examine what standards are required in this wider context.

3.28 The *National Quality Standards for Residential Care Settings for Older People in Ireland* provide that the finances of the resident must be safeguarded. Registered care providers are required to have a clear policy and procedure regarding the management of resident's accounts and personal property.³⁸ The standards require that where staff members handle any money belonging to the resident, signed records and receipts must be kept, and where possible these must be signed by the resident or a representative.³⁹ The care provider must ensure that there are secure facilities in which the resident's money or other valuables may be kept⁴⁰ and a record must be maintained of all such items.⁴¹ The Standards do not require the contract to take account of these provisions, rather service providers are required to establish policies and procedures to ensure that service user's finances and personal property are protected.

3.29 The English Standards set out detailed requirements which must be followed where the registered person is drawing up policies and procedures for staff who are handling service users' money and property.⁴² These provisions cover situations where the care worker is handling the service user's finances to pay for a service or bill, for example or to pay for shopping or to collect the service user's pension. The Standards also set out situations in which the care worker may not handle the service user's money, including the borrowing or

³⁷ Available at www.justice.ie.

³⁸ Standard 9.1 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

³⁹ Standard 9.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁴⁰ Standard 9.5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁴¹ Standard 9.6 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁴² Standard 13.1 of the *Domiciliary Care – National Minimum Standards*.

lending of money by the service user, the offering of gifts or cash by the service user and the sale or disposal of goods belonging to the service user.⁴³

3.30 Both the English and Welsh Standards require that a record must be maintained in the service user's home of all financial transactions undertaken on behalf of, or support given to, the service user.⁴⁴ The Scottish Standards set out basic provisions for the recording of financial transactions, but do not make the same detailed requirements that the English and Welsh standards do.

3.31 There is nothing in either the English or Welsh standards which requires financial protection provisions to be included in the terms and conditions of the care contract. The standards do require clear policies and procedures to be drawn up in order to offer the service user financial protection. There is a provision in the English Standards which requires the care contract to take account of the liability of each party if there is any damage occurring in the home.⁴⁵ This could be interpreted as including damage to the personal property of the service user.

3.32 *The Commission provisionally recommends that the care contract should contain clear policies and procedures in relation to the handling by the carer of money and personal property of the service recipient. The Commission also provisionally recommends that there should be clear policies in place regarding the refusal of gifts from the service recipient.*

(4) Medication management

3.33 The over-prescription of medications, particularly of anti-psychotic medication for people with dementia, is a major difficulty in the care of vulnerable adults.⁴⁶ Medicines are sometimes used in the care environment as a tool for managing service users and ensuring that the care of people with dementia is easier for staff.⁴⁷ The responsibility for the administration of medicines for older people in care settings very often rests with care staff, but many lack sufficient experience or knowledge of the management of medicines.

⁴³ For more detail see standard 13 of the *Domiciliary Care – National Minimum Standards*.

⁴⁴ Standard 13.4 and standard 16 of the *Domiciliary Care – National Minimum Standards* and Standard 16.1 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

⁴⁵ Standard 4.2 of the *Domiciliary Care – National Minimum Standards*.

⁴⁶ For more see House of Commons Health Committee *Elder Abuse* Second Report of Session 2003-2004, Volume 1.

⁴⁷ *Ibid* at 18.

This may lead to errors occurring, particularly when the care workers have not received adequate training in the safe practice of administering medicines. The Leas Cross report, found that although regular medication review is a standard part of the care of older people. This was not followed in Leas Cross, and nearly all prescriptions were written in a different handwriting to that of the doctor's signature. No written policy was offered to support regular medication review.⁴⁸

3.34 In Ireland residential care providers are required to establish policies and procedures for the management of medication.⁴⁹ The Standards require that records are kept to account for all medicines received and administered.⁵⁰ Staff must adhere to procedures for the safe administration of medication, for prescription, supply, receipt, self-administration by residents, recording, storage, handling and disposal of medicines that accord with legislation and professional regulatory requirements or guidance.⁵¹ Residents may self-administer their own medication, and staff must promote the resident's understanding of their health needs as they relate to medication.⁵² All medication errors are recorded, reported and analysed.⁵³ The Standards also provide that the residential care setting must monitor and review the resident's medication programme every three months. This is to protect residents from unnecessary illness caused by excessive, inappropriate or inadequate consumption of medicines.

3.35 In England, where a domiciliary care agency arranges for the personal care of a service user, these arrangements must specify the circumstances in which a domiciliary care worker may administer or assist in the administration of medicines to the service user and the procedures to be

⁴⁸ For more information, see *A review of the deaths at Leas-Cross Nursing Home 2002-2005* (O'Neill Report) (HSE, 2006).

⁴⁹ Standard 14 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁵⁰ Standard 14.5 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁵¹ Standard 14.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁵² Standard 14.10 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁵³ Standard 14.4 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

adopted in these circumstances.⁵⁴ The Domiciliary Care Standards in England do not specifically require that these arrangements for the management of medicines be documented in the care contract. However, the care contract is required to specify any:

“areas of activity which home care or support workers will and will not undertake and the degree of flexibility in the provision of personal care...”⁵⁵

This provision could be interpreted as including the management and monitoring of the administration of medication to home care recipients. Furthermore, the English Standards require that the registered person of an agency must ensure that there is a clear written policy and procedure which identifies the parameters and circumstances for assisting with medication and health related tasks, the limits to assistance, and tasks which may not be undertaken without specialist training.⁵⁶ Staff may only assist with the taking of or the administration of medication, when it is within their competence and they have received any necessary specialist training. The service user must also give his or her informed consent.⁵⁷

3.36 HIQA's *Standards for Residential Care Settings for Older People in Ireland* set out specific requirements in relation to the management and administration of medication. The standards also make certain requirements in relation to the monitoring and review of medication management. However, there is nothing which requires the monitoring of medication to be included in the contract.

3.37 Under recent legislation, a nurse who works for a health service provider in a nursing home or in a private home where the health service is

⁵⁴ Regulation 14(6)(b) of the *Domiciliary Care Agencies Regulations 2002*. Regulation 14(5)(b) of the *Domiciliary Care Agencies (Wales) Regulations 2004* makes a similar provision.

⁵⁵ Standard 4.2 of the *Domiciliary Care – National Minimum Standards*. The *National Minimum Standards for Domiciliary Care Agencies in Wales* make a similar provision under standard 5.2.

⁵⁶ Standard 10.3 of the *Domiciliary Care – National Minimum Standards*. See also standard 10 of the *National Minimum Standards for Domiciliary Care Agencies in Wales 2004*. The *Scottish National Care Standards: Care at Home*, also require that the service provider has policies and procedures in place regarding the administration of medication, see standard 4 for more information.

⁵⁷ Standard 10.3 of the *Domiciliary Care – National Minimum Standards*.

provided has the authority to prescribe medications.⁵⁸ There are certain conditions attached to this authority namely that the medicinal product must be one that would ordinarily be given in the usual course of the service, and the prescription must be one that would be issued in the usual course of the provision of that health service. This development highlights the importance of monitoring the administration of medications to home care recipients.

3.38 Given the vulnerable position of people receiving home care services and the importance of preserving their independence and autonomy, the issue of administering medication is important. The arrangements agreed by both the service user and the service provider should include details of the administration and monitoring of medication. This would help to identify any mis-management of medicines, and would help to ensure that medicines are used as part of a proper treatment plan, and not to control unruly service users. This would also help to make certain that service users are protected from abuse and that their autonomy and independence is respected.

3.39 *The Commission provisionally recommends that the care contract should set out specific policies and procedures in relation to the management of a service recipient's medication.*

(5) Complaints procedures

3.40 A contract is a legally enforceable document. Each party to a contract can rely on this document to make sure that the other parties comply with their responsibilities under the contract. If one party breaches the terms and conditions of the contract, then the other party can take legal action to enforce the contract.

3.41 In order to protect service users and to further ensure the quality of the service being provided, a robust complaints procedure must be in place to deal with complaints made by service users or somebody on their behalf. The complaints procedure should take account of the inherent vulnerability of those receiving care in their own homes and their general reluctance to make a complaint. For this reason, it is important that the complaints procedure is set out clearly, and is accessible to the service user. The procedure should ensure that any formal complaint is investigated efficiently, and any appropriate action is taken.

3.42 In Ireland the *National Quality Standards for Residential Care Settings for Older People in Ireland*, state that any complaint made by a

⁵⁸ Section 4 of the *Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007*. For more information see *An Bord Altranais Guidance to Nurses and Midwives on Medication Management July 2007* available at www.nursingboard.ie.

resident (service user) or someone on their behalf, must be acted upon, and fully investigated.⁵⁹ The standards detail specific requirements with regard to the operation of the complaints procedure.⁶⁰ However, there is no requirement under these standards for the complaints procedure to be included as part of the terms and conditions of the contract of care.

3.43 Under the English *Domiciliary Care Agencies Regulations 2002*, all agencies providing home care must have a complaints procedure in place to deal with complaints made by the service user or someone on their behalf.⁶¹ A written copy of the complaints procedure must be given to each service user.⁶² The registered person of the agency has 28 days in which to take action to deal with a complaint and he or she must also maintain a record of each complaint and any steps taken to deal with the complaint.⁶³ The English standards set out further details that the complaints procedure must take account of, such as record keeping and timescales for the process.⁶⁴ The English and Welsh standards require that the complaints procedure is set out in the service user's guide, but do not require the procedure to form part of the terms and conditions of the contract or agreement for care.⁶⁵

3.44 Due to the inherent vulnerability of many recipients of home care, and potential mental capacity issues, the Commission wishes to ensure that

⁵⁹ Standard 6 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁶⁰ Standard 6.3 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁶¹ Regulation 20(1) of the *Domiciliary Care Agencies Regulations 2002*.

⁶² Regulation 20(2) of the *Domiciliary Care Agencies Regulations 2002*.

⁶³ Regulation 20(5) of the *Domiciliary Care Agencies Regulations 2002*. The *Domiciliary Care Agencies (Wales) Regulations 2004* make provisions similar to the *Domiciliary Care Agencies Regulations 2002* in Regulation 21.

⁶⁴ Standard 26 of the *Domiciliary Care – National Minimum Standards*.

⁶⁵ The service user's guide provides comprehensive information regarding all aspects of the organisation of the agency, and the delivery of the care, including details of the complaints process. For more detail see standard 1.2 of the *Domiciliary Care – National Minimum Standards*, and standard 1.2 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*. Similarly, the *Scottish National Care Standards: Care at Home* do not require the complaints procedure to form part of the written agreement for care, but details of the procedure must be included in the introductory pack which is provided to each service user as per Standard 1.

vulnerable adults do not have to utilise the courts system in order to enforce the terms and conditions of their contract of care. In its *Report on Vulnerable Adults and the Law*, the Commission recommended the establishment of a new independent Office of Public Guardian.⁶⁶ The current Draft *Scheme of Mental Capacity 2008* as published by the Department of Justice mirrors much of the recommendations of the Commission's Report. The Scheme provides for the establishment of an Office of Public Guardian, to oversee and supervise the arrangements for substitute decision-making for adults who lack capacity.⁶⁷ One of the key functions of the Office would be to enable the Public Guardian to deal with representations (including complaints) regarding the manner in which a donee of an enduring power of attorney or a personal guardian appointed by a court, is exercising his or her own powers.⁶⁸

Where an individual has entered a contract for the provision of services, and is concerned that the service provider has breached the terms and conditions of the contract to the extent that the health and well-being of the individual may be compromised, then a complaint should be made to the Office of the Public Guardian. In light of the vulnerability of those who receive home care and the need to avoid the adversarial courts system, the Commission considers that the powers and functions of the Public Guardian could be extended to enable the Office to provide for those vulnerable adults who have not executed an enduring power of attorney, or a court appointed personal guardian. This would allow the Public Guardian to receive and deal with representations and complaints regarding the domiciliary care being provided to individuals. The extension of the function of the Public Guardian would enable vulnerable adults to resolve any issue there may be over a breach of the contract without having recourse to the adversarial courts system. Instead any issue about the breach or alleged breach of a contract for the provision of domiciliary care could be referred to the Public Guardian.

(6) Conclusion

3.45 The care contract should protect individuals and domiciliary care providers alike, by setting out the certain terms and conditions of the provision of domiciliary care services, as agreed between the parties. These terms and conditions should refer to the competence of the service provider, and its ability

⁶⁶ Law Reform Commission *Report on Vulnerable Adults and the Law* (LRC Report 83-2006) at 7.14.

⁶⁷ Part 2 of the *Scheme of Mental Capacity Bill 2008*. Head 28 of the Bill establishes the Office of Public Guardian, while Head 32 sets out the objectives and functions of the Office.

⁶⁸ *Ibid* at Head 32(2)(i).

to provide the appropriate services to meet the client's needs. The specific details about the provision of the care services should also be set out in the care contract. This would ensure that each party knows exactly what services are to be provided and what services are not to be provided. Any agreed policies and procedures that relate to the protection of the service recipient, including any complaints procedure and any agreed policy on the administration and management of the service recipient's medicines should be included in the care contract.

D Conclusion

3.46 The care contract must be informed by public standards as set out by HIQA. This care contract should set out general policies and procedures in relation to specific aspects of the provision of domiciliary care. In particular certain issues such as protection and medication management should be covered by the care contract, in order to ensure that the vulnerable adult is adequately protected.

3.47 The Commission turns in the next chapter to the contracting arrangements for the provision of domiciliary care services.

CHAPTER 4 CONTRACTING ARRANGEMENTS

A Introduction

4.01 In this Chapter, the Commission discusses the different contracting arrangements that may be involved in the provision of domiciliary care services. It is important that the legal effects of these different arrangements on all parties - the State, service providers and service recipients - are clearly understood. In particular, the Commission notes the significant different effects of being, on the one hand, an employer of a service provider and, on the other, engaging a service provider as a contractor. The Commission discusses this distinction in Part B. In Part C, the Commission examines the importance of ensuring that the contracting arrangements for the provision of domiciliary care services are transparent. The Commission discusses in this respect the different types of financial contracting arrangements that may be in place, ranging from complete or part-financing by the HSE, State subventions, complete or part-payment by the service recipient to the HSE, related tax treatment and completely private arrangements by the service recipient with care providers. In Part D, the Commission discusses the impact of the responsibilities that arise under employment law on domiciliary care contracts. In Part E, the Commission examines the situation where a person's mental capacity may affect an individual's ability to enter into a contract.

B Contracting arrangements: who is the employer of the service provider?

4.02 It is extremely important to know who is the employer of a domiciliary care provider, because this carries significant legal responsibilities. The employer must comply with many statutory obligations under employment legislation,¹ including providing a written contract of employment, compliance with working time obligations (such as limits on hours of work, holidays and maternity leave) and safety and health requirements. In addition, the employer

¹ Fennell and Lynch *Labour Law in Ireland* (Gill & Macmillan 1993) at 115.

is responsible for relevant social welfare and tax returns for employees.² The Commission discusses these obligations in Part D.

4.03 In the context of domiciliary care provision, the HSE is currently the largest employer in this respect as it employs a large number of individuals who provide professional home care organised through the HSE community care system. As the Commission has already noted, a number of private sector businesses have also become engaged in providing domiciliary care in Ireland in recent years, and these businesses would also be seen as employers in this respect.

4.04 In general, therefore, service recipients would not ordinarily be employers of the individuals who provide domiciliary home care, because those individuals are already employees of, for example, the HSE or the private sector home care providers. There may, however, be situations where a service recipient could become an employer and it is important to discuss the way in which the law determines this. For the purposes of employment law, an employer is a person who enters into a “contract of service” with an individual; the employer usually also pays an employee an agreed wage or salary, often paid weekly or monthly. By contrast, if a person agrees a fee rather than a wage for an individual’s, or a company’s, services – called a “contract for services” – the person paying the fee does not become an employer. Instead, if an individual is providing the services he or she is usually regarded as a self-employed “independent contractor” and, if the services are provided by a company, the company is the employer of the individual who actually comes into the client’s home to provide the domiciliary care.

4.05 It is clear that, in most existing arrangements involving domiciliary care, a service recipient is not the employer. The recipient could, however, be an employer if he or she were to enter into a direct contractual arrangement with an individual on the basis that, in return for the individual providing 6 hours domiciliary care per week, the care recipient would give the carer €150 per week. The care recipient and the care provider might not have said to each other “and, of course, this is a contract of employment” but in legal terms that is the effect of the contractual arrangement. The Commission emphasises that, in the majority of existing arrangements for domiciliary care, the HSE or private sector care providers are clearly in the position of employer but it is important to understand why this is so.

4.06 Although there are no definitive criteria for determining whether a contract is one “of service” (employer-employee) or “for services” (engaging an independent contractor) some relevant factors include those mentioned such as

² McAteer, Reddin and Deegan *Income Tax: Finance Act 2008* Bolster (ed) (Irish Taxation Institute 2008 21st Ed) at 464.

payment arrangements, working hours and the degree of control over the individual engaged. In *Henry Denny & Sons Ltd v. Minister for Social Welfare*³ the Supreme Court agreed that various tests can be applied in this respect and that no single factor is definitive. The 2007 *Code of Practice for Determining Employment or Self-Employment Status of Individuals*⁴ provides a list of detailed criteria, which are based on the key economic question: “Is the person a free agent with an economic independence of the person engaging the service?” The Code of Practice does not have statutory force but states that an individual would normally be an employee if he or she:

- is under the control of another person who directs as to how, when and where the work is to be carried out
- supplies labour only
- receives a fixed hourly/weekly/monthly wage
- is not exposed to personal financial risk in carrying out the work
- does not assume any responsibility for investment and management in the business
- does not have the opportunity to profit from sound management in the scheduling of engagements or in the performance of tasks arising from the engagements
- works set hours or a given number of hours per week or month
- works for one person or for one business
- receives expense payments to cover subsistence and/or travel expenses
- is entitled to extra pay or time off for overtime

4.07 These criteria support the view that the majority of domiciliary care arrangements would not involve the care recipient being an employer.

4.08 Indeed the Commission considers that, even in the relatively small percentage of cases where an individual wishes to enter into an arrangement to purchase domiciliary care services from an individual carer, it should be possible for this to be done through an intermediate body, whether the State in the form of the HSE or a private sector provider who would arrange for the provision of care with the individual domiciliary carer and also be regarded as employer. Of course, individuals remain free to take on the responsibility of being the employer but the Commission considers that it might be appropriate for there to be a choice available in this regard, and it invites submissions on this issue.

³ [1998]1 IR 34.

⁴ Available at www.welfare.ie. The Code of Practice was prepared by the Employment Status Group to ensure that individuals were given an appropriate employment status, both to prevent tax evasion and to ensure that individuals received appropriate social insurance protection.

4.09 *The Commission provisionally recommends that an individual who wishes to enter into an arrangement for the provision of domiciliary care services should have the option to contract with an intermediary, whether a State body or a private sector body, who would arrange for the provision of care and who would assume the responsibilities of an employer towards the domiciliary carer.*

C Contractual transparency

4.10 In this Part the Commission discusses the need for transparency in the contractual arrangements for the provision of domiciliary care. This is especially important to ensure that the employment status surrounding the parties is well understood. There is the added dimension that many of those who need domiciliary care services are potentially vulnerable to abuse, including financial abuse. In this regard, it is important that any contractual arrangements be based on a template, related to the proposed national standards to be developed by HIQA, and should identify such matters as the various contracting parties, including the recipient and provider of the care services, the financial arrangements between the parties and the specific services covered by, and those excluded by, the contract.

(1) Contracting parties

4.11 It is clear that any template-based care contract should identify the contracting parties. On one side of the arrangement, the contract must identify the party that is providing and charging for the service. This could be the HSE, a voluntary organisation, a private domiciliary care agency or an individual professional. On the other side of the arrangement, the party that is receiving the service must be identified. The contract should also identify the party paying for the service, who may be the service recipient themselves, someone on his or her behalf, or the State, through the HSE. The Commission turns to examine the various methods that might be involved in this respect.

(a) Contracting with the HSE

(i) HSE funded care

4.12 Where the HSE completely funds and directly provides the home care, the service user will not be involved in the financial arrangements concerning the care contract. If the HSE purchases care from some other care provider, the care contract will be agreed between the HSE and that care provider. In such a case, the Commission considers that the HSE and the service provider should consult with the service user in order to ascertain their wishes and desires regarding their care, and to ensure that the service user is involved in the decision-making process.

(ii) Services part-financed by HSE

4.13 The HSE may also part-finance the provision of home care, for example through the administration of a home care package, or some other payment. Under the current Home Care Support Scheme, home care may be provided by voluntary and community organisations on behalf of the HSE. In some instances, a package might have consisted of a financial package which the service user could then use to engage a private carer or home help service. The Commission understands that this form of cash grant home care package is rare, and is no longer available in many HSE areas. In any event, it is important that there is a formal record of any financial arrangement and that, where the State is part-financing the provision of care, this must also be recorded.

(iii) Community-based subventions

4.14 In its 2005 *Care for Older People Report*, the National Economic and Social Forum (NESF) strongly supported the concept of community-based subventions towards the care needs of those in community settings.⁵ The NESF submitted that the development of community-based subventions should be considered in the context of the overall policy of promoting care at home.⁶ The NESF recognised that community-based subventions are advantageous, as they support older people's preferences for living at home for as long as possible, in line with the policy objective outlined in the social partnership programme *Towards 2016*. Community-based subventions are generally cost-effective in comparison to the cost of nursing homes or extended hospital stays.⁷

4.15 The *Nursing Homes Support Scheme Act 2009* establishes a scheme which aims to provide a uniform system of financial support to individuals in long term residential care services, often referred to as the "fair deal" scheme. The purpose of the scheme is to ensure that no one would be put in a position where they have to sell their home during their lifetime in order to fund their care. The scheme also contains safeguards to ensure that, where the spouse or partner of an individual who seeks State support remains living in the principal residence, he or she retains enough income to live comfortably and

⁵ National Economic and Social Forum *Care for Older People Report* (Report 32, November 2005) at 3.24.

⁶ National Economic and Social Forum *Care for Older People Report* (Report 32, November 2005) at 3.21.

⁷ *Ibid* at 3.23.

does not have to sell or mortgage the home to provide for themselves.⁸ In the Oireachtas debates on the 2009 Act, the issue of extending the support scheme to incorporate community-based services was raised. While this is not included in the 2009 Act, it is clear that an extension of the scheme to community-based care is consistent with Government policy.⁹

4.16 Under the 2009 Act individuals who apply for State assistance to help cover the cost of their care,¹⁰ can choose between public or private nursing homes.¹¹ Where a person chooses a public nursing home, their assessed contribution¹² is paid to the HSE, and the State pays the balance. Where an individual chooses a private nursing home, their contribution is paid to the private nursing home, and the State pays the balance of the cost of care to the private nursing home. The Commission endorses this approach to financing the cost of care. Nursing homes who wish to be placed on the HSE's list of approved facilities under the 2009 Act apply to the National Treatment Purchase Fund (the NTPF).¹³ The NTPF then negotiates the cost of the service with the applicants, and then enters into an Approved Nursing Home Agreement, which contains the details of the financial arrangements. Once this is completed, the NTPF then provides the HSE with a list of providers with which it has an Approved Nursing Home Agreement.

4.17 Under the 2009 Act, people availing of residential care will make a contribution towards the cost of their care in accordance with their means. This

⁸ Part 2 of Schedule 1 of the *Nursing Homes Support Scheme Act 2009*.

⁹ See Vol. 195 Seanad Debates, 10 June 2009, in which Minister of State at the Department of Health and Children, Áine Brady TD stated: "Many Senators raised the issue of support for community-based services, bearing in mind that this Bill provides support for residential services. The Government is committed to community-based supports for older people and has allocated an additional €200 million towards the provision of community-based services over the past three years. The Government is committed to continuing to emphasise community-based care." Available at <http://debates.oireachtas.ie>.

¹⁰ Section 5 of the *Nursing Homes Support Scheme Act 2009*.

¹¹ Section 12 of the *Nursing Homes Support Scheme Act 2009*.

¹² Part 1 of Schedule 1 of the *Nursing Homes Support Scheme Act 2009*.

¹³ Under section 40 of the *Nursing Homes Support Scheme Act 2009*, the National Treatment Purchase Fund was designated as the body authorised to negotiate with proprietors of registered nursing homes to reach agreement in relation to the maximum price(s) that will be charged for the provision of long-term residential care services to Nursing Homes Support Scheme residents. See www.ntpf.ie.

figure will not exceed 80% of a person's assessable income and 5% of the value of his or her assets, including his or her principal residence.¹⁴ After their death, and the death of their spouse or partner, if any, a maximum of 15% of their estate will be paid to the State in the form of a deferred contribution. Where a person selects a public nursing home, their contributions are made payable to the HSE, with the State funding the remainder of the bill. If a person selects a private nursing home, they pay their contribution to the nursing home, and the State pays the remainder of the cost.

4.18 The Commission acknowledges the positive impact that the *Nursing Homes Support Scheme Act 2009* will have in bringing about greater clarity and protection to older persons in residential care settings, as well as to their spouses and partners. The Commission supports the views expressed in the Oireachtas debates on the 2009 Act,¹⁵ and previously by the NESF, that community-based subventions should be incorporated into the overall policy for care of older people. This would advance stated government policy to support older people to remain in their own homes for as long as is possible, and to support community-based care.¹⁶

4.19 *The Commission invites submissions as to whether a subvention arrangement, comparable to that for nursing homes in the Nursing Homes Support Scheme Act 2009, should be extended to community-based provision of domiciliary care.*

(iv) Contracting with the HSE

4.20 The HSE is currently responsible for providing domiciliary care in accordance with the various community-based home care packages already in place. If a person wishes to apply for domiciliary care from the HSE, he or she usually contacts the public health nurse at their local health office. The public health nurse then assesses the needs of the individual, and makes a determination as to what, if any, domiciliary care services the individual needs. The Commission understands that in some HSE areas, the public health nurse assesses individuals and then classifies them into different categories depending on their level of need. In general, those with a medical card, who have high dependency needs, as well as some people with terminal illnesses

¹⁴ *The Nursing Homes Support Scheme "A Fair Deal" Information Leaflet* (Department of Health and Children, Government Publications, October 2008) available at www.dohc.ie/press/releases.

¹⁵ Seanad Debates Vol. 195, 16 June 2009.

¹⁶ *Towards 2016: Ten-Year Framework Social Partnership Agreement 2006-2015* (Department of the Taoiseach, Government Publications, 2006) at Section 32: Older People.

receive a home care package. Individuals are entitled to have their needs assessed, but they are not entitled to receive the services that they are assessed as needing. Thus, public health nurses have a significant role in whether a person receives home care from the HSE.

4.21 Where a person is in need of domiciliary care and has the means to purchase the care themselves, they have the option of either entering into a contractual arrangement with a private domiciliary care agency or an individual professional carer. As already discussed above, where a person has the means to purchase domiciliary care the option should be available of entering into a contractual arrangement directly with the HSE to purchase the services from the HSE or from some other agency or individual professional through the HSE. This option would be a mirror image of one version of the Home Care Support Scheme which, as discussed in Chapter 1, can involve the HSE providing a cash grant to individuals to enable them to purchase care services privately. If individuals were able to contract with the HSE for the provision of domiciliary care services, this could greatly assist the care recipients, some of whom are vulnerable, including in terms of potentially having responsibilities as an employer were they to enter into an employment contract (contract of service) with an individual professional carer. The care services could include those typically involved in a care package, such as physiotherapy, chiropody, occupational therapy, speech therapy and general home help services, as well as professional carers providing personal care. The HSE could initiate a tender process for the different areas, in which providers who are registered with HIQA would be able to offer their services. The HSE would also be in a position to negotiate better rates than would be likely for an individual, thereby ensuring that the individual gets the best service for the best value. This would also ensure that the HSE has a record of all people providing services to older people with whom it has a contract with. This would also allow the individual to choose their care provider from a list of service providers. By allowing individuals to purchase care services from or through the HSE, they can fund their care themselves, while avoiding any potential responsibilities under employment law.

4.22 *The Commission provisionally recommends that an individual who wishes to pay for the provision of domiciliary care services should have the option to contract directly with the HSE for such services.*

(v) Assessment of need

4.23 In order to ensure that a person receives the appropriate domiciliary care that is appropriate to his or her needs, it is important that an assessment of need is conducted. This assessment would identify the specific needs that the individual has, and would allow the service provider to determine how best to meet those needs. In 2007, the National Disability Authority published

Standards for the Assessment of Need,¹⁷ which HIQA then adopted after it was established.¹⁸ The standards represent a new approach to assessing the needs of eligible persons with disabilities and/or special educational needs for health and/or educational services.¹⁹ The standards set down the desired and achievable levels of performance against which actual performance can be measured.²⁰ The aim of the standards is to ensure that each assessment is “person-centred”, in other words, that each assessment is conducted in a manner which focuses primarily on the individual being assessed.²¹ In promoting the “person-centred” approach to the assessment, the standards provide for the participation of the individual in the assessment process.²² Throughout the assessment, the individual must be appreciated and their dignity and privacy must always be respected.²³ The assessment process must be kept as simple, efficient and accessible as possible, and the individual must be kept fully informed about all aspects of the process.²⁴ The assessor must, in addition to being suitably qualified and having the relevant experience, have up to date Garda Vetting Clearance.²⁵ This is essential, as any person who is carrying out an assessment of need will be in close contact with vulnerable persons.

4.24 While there are standards in place to assess the need of persons with disabilities for health and/or educational services in Ireland, there are currently no standards by which the need for domiciliary care can be assessed. Where the HSE is providing, or co-ordinating the delivery of, the domiciliary care, the individual concerned is entitled to an assessment of need. However, if a person enters into a private arrangement for the provision of care, then an assessment of need may be carried out to assess the services they require. If an individual can afford to pay for those services directly then he or she should be facilitated in obtaining the services.

¹⁷ *Standards for the Assessment of Need*, available at www.hiqa.ie.

¹⁸ In accordance with section 10 of the *Disability Act 2005*.

¹⁹ In accordance with the *Education for Persons with Special Educational Needs Act 2004* and *Disability Act 2005*.

²⁰ *Standards for the Assessment of Need*, at p5, available at www.hiqa.ie.

²¹ *Ibid.*

²² Standard 1.4 and 1.5.

²³ Standard 1.2.

²⁴ Standard 3.1.

²⁵ Standard 4.2.

4.25 While the Commission considers that this aspect of the Consultation Paper is worthy of discussion, it has concluded that the issue of assessment of need in the context of the provision of domiciliary care is a matter of policy which is ultimately a matter for Government to determine. In those circumstances, the Commission does not consider it appropriate to make any recommendation on this topic.

(vi) Tax relief

4.26 State benefit in the form of tax relief is also available to a person who pays for residential care, but this relief is currently not available to a person who pays directly for professional domiciliary care. Tax relief is available to an individual in respect of health expenses incurred in a tax year. The amount of relief generally available for health expenses is equal to the standard rate of tax and such expenses would include medical procedures and drugs. Health expenses are defined in section 469 of the *Taxes Consolidation Act 1997* as including expenses incurred in relation to maintenance or treatment in a nursing home, and where it is proved that an individual has incurred nursing home fees the tax relief is more generous. The 1997 Act provides that the individual is entitled, for the purpose of ascertaining the amount of the income on which he or she is to be charged income tax, to have a deduction made from his or her total income of the amount proved to have been defrayed on fees paid to a nursing home. There is, however, no similar tax relief available to a taxpayer who incurs expenditure for domiciliary care in his or her own home.²⁶ In the Commission's view, this appears to be inequitable and, moreover, not to be consistent with stated government policy to encourage community-based care. For that reason, the Commission has concluded that section 469 of the *Taxes Consolidation Act 1997* should be extended to provide for tax relief for fees incurred by an individual in meeting the cost of domiciliary care.

4.27 *The Commission provisionally recommends that section 469 of the Taxes Consolidation Act 1997 should be extended to provide tax relief for fees incurred by an individual in meeting the cost of domiciliary care.*

(b) Private contractual arrangements

4.28 Where a service user enters into an agreement with a private sector home care provider and pays for the cost of the service themselves the Commission considers that, consistently with the position where the service is provided through the HSE, the contract should set out specific details of this

²⁶ Section 466A of the *Taxes Consolidation Act 1997* provides for claiming a Tax Credit (known as Home Carer's Tax Credit) in certain circumstances. However, the Tax Credit can only be claimed by persons whose income is less than €5,080 per annum and is not applicable to professional home care provision.

financial arrangement. Issues such as the amount of the cost of care, the method of payment and the regularity of such payments should be agreed between the parties and recorded in the contract.

(i) Domiciliary care agency

4.29 As discussed in Part B, where an individual uses their own funds (or, less commonly, a cash grant provided through a home care package), to contract with a private domiciliary care agency, he or she does not take on the status of employer. The domiciliary care agency that employs the professional carer remains the employer, and the contract between the individual care recipient and the domiciliary care agency is, as discussed in Part B, a contract for services.

4.30 In order to ensure financial transparency, the Commission is of the view that such a contract for care should identify the contracting parties and that it should formally set out the financial arrangement for payment for the service.

(ii) Individual professional carer

4.31 Where a service user chooses to contract with an individual professional carer for domiciliary care services, it may be that, in accordance with the 2007 *Code of Practice for Determining Employment or Self-Employment Status of Individuals*,²⁷ the service user could also be taking on the status of employer. If, for example, the carer is under the control of the service recipient, if he or she receives a fixed wage and works set hours, supplies the labour only and not any materials, the carer is likely to be considered to be the employee of the service recipient. It may be that these situations are likely to represent a minority of cases where domiciliary care is sought and provided, but in the Commission's view they also highlight a potential set of situations to which the proposed national standards to be developed by HIQA might not extend because the care provider may not be registered as such. This reinforces the importance of having in place the option for service recipients of being able to contract directly through an intermediary, whether private sector or the State, for the home care service provision. The Commission has therefore come to the conclusion that there should be public education of the fact that a service user could be regarded as an employer of a professional carer if the service user does not contract directly through an intermediary, whether private sector or the State, for the provision of professional domiciliary care.

4.32 *The Commission provisionally recommends that there should be public education of the fact that a service user could be regarded as an employer of a professional carer if the service user does not contract directly*

²⁷ Available at www.welfare.ie.

through an intermediary, whether private sector or the State, for the provision of professional domiciliary care.

(iii) Contracts with other individuals that are not care contracts

4.33 The scope of the domiciliary care contracts to which the proposed national standards to be developed by HIQA will apply is, it should be noted, limited. They will not extend, for example, to other home-related work which a home owner may enter into, such as general cleaning, electrical maintenance or gardening. These contracts will, of course, give rise to questions as to whether the home owner is an employer of, for example, the cleaner (contract of service) or has engaged the cleaner as an independent contractor (contract for services). These contracts would be outside the terms of reference of the proposed national standards for domiciliary care to be developed by HIQA. The Commission considers, however, that such arrangements could be subject to the general supervision of the proposed Office of the Public Guardian (OPG), which the Commission recommended in its 2006 *Report on Vulnerable Adults and the Law*²⁸ and which the Government's *General Scheme of a Mental Capacity Bill 2008*²⁹ proposes to establish. The monitoring arrangements to be put in place under the OPG have been discussed in Chapter 3.³⁰

(2) Financial arrangements

4.34 Financial abuse has been highlighted as one of the forms of abuse to which vulnerable adults are most susceptible.³¹ Financial abuse has been defined as the "intentional or opportunistic appropriation of the income, capital or property of a vulnerable person through theft, fraud, deception, undue influence or exploitation."³² This can include the hoarding of a vulnerable person's resources for future gain.³³ Financial abuse can be perpetrated by family members, neighbours, friends or anyone in a position of trust, and as

²⁸ LRC 83-2006. See the Introduction, paragraph 2, above.

²⁹ Available at www.justice.ie. See also the Introduction, paragraph 2, above.

³⁰ See paragraph 3.44, above.

³¹ UK Department of Health *No Secrets – guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (2000), and Report of the Working Group on Elder Abuse, *Protecting Our Future* (Stationery Office, Dublin, 2002), p25.

³² Salomons *The Role of the Public Guardianship Office in safeguarding vulnerable adults against financial abuse* (Canterbury Christ Church University College).

³³ *Ibid.*

such can make it very difficult to detect. Of the more than 1,800 cases of elder abuse reported to the HSE in 2008, 16% involved incidents of financial abuse.³⁴

4.35 In this respect, it is useful to examine the standards drawn up by HIQA in terms of financial transparency in the care contract concerning residential care services. The HIQA 2008 *Standards for Residential Care Settings for Older People* require the service provider to provide each resident with a written contract setting out the fees that are payable, and identifying who is to pay these fees.³⁵ The contract must identify who is to pay these fees, be it the service user, a representative or a family member(s), the HSE, or some other party. The contract must also specify what overall services are covered by this fee, and what services are not.³⁶ If there are to be any additional health, personal and social care services beyond this, the Standards require that these are expressly set out in the contract for care.

4.36 Similarly, HIQA's 2009 *National Standards for Residential Care Settings for People with Disabilities* provide that the individual service agreement – a type of contract - must set out the nature and extent of the services being provided and whether any charges are to be applied for these services, what the charges cover and whether particular supports are only available on payment of extra charges.³⁷

4.37 From a comparative perspective, it is also useful to examine how other States deal with the financial transparency of the contractual arrangement for the provision of domiciliary care. The English Domiciliary Care Standards require that the contract for the provision of care makes provision for the fees payable for the service, and who is to make these payments. The Scottish Standards also require that the written agreement for services takes account of the charges for the relevant services, and how the service user will make the payments.³⁸

4.38 It is clear from these various standards documents that, regardless of who is funding the service, the financial arrangement for the provision of

³⁴ National Elder Abuse Steering Committee *HSE Elder Abuse Service Developments 2008: Open Your Eyes* 2008, at p.27, available at www.hse.ie.

³⁵ Standard 7 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

³⁶ See standard 7.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland* for more discussion on this point.

³⁷ Standard 13.11 of the *National Quality Standards for Residential Care Settings for People with Disabilities*.

³⁸ Standard 2.2 of the *National Care Standards – Care at Home*.

domiciliary care services is agreed between the parties and formally recorded. The contract for care should specifically identify the contracting parties, and should set out in clear terms the financial arrangement for the funding of the provision of home care. Indeed, in the Commission's view, the private setting in which home care is provided may require that the contract for care should set out more specific details in terms of the handling of a service user's money and property than is required, for example, under HIQA's standards for residential care. On this basis, the Commission has concluded that any contract for the provision of domiciliary care services should include specific provisions that set out the financial arrangement between the contracting parties for the agreed services.

4.39 The Commission provisionally recommends that any contract for the provision of domiciliary care services should include specific provisions that set out the financial arrangement between the contracting parties for the agreed services.

D Some specific employment law responsibilities

4.40 As already mentioned, the employer in a domiciliary care setting (usually, the HSE or other service provider, but occasionally the service recipient) takes on a wide range of responsibilities under employment law. In this Part, the Commission discusses these responsibilities in general and also discusses some specific aspects arising under safety and health at work legislation. The main purpose of this discussion is to draw attention to the complexity of the relevant law, which is most likely apply to the HSE and private sector service providers. In addition, since these issues are discussed in the existing HIQA national standards for the residential care setting, the Commission considers that they should also be addressed in the proposed national standards for the domiciliary care setting.

(1) General responsibilities under employment law

4.41 The HIQA *National Quality Standards for Residential Care Settings for Older People* require that the contract between the resident and the registered provider takes account of the rights, obligations and liability of both contracting parties.³⁹ The Standards do not set out what specific rights and obligations the contract should detail. A similar requirement is made under HIQA's 2009 *National Quality Standards for Residential Care for People with Disabilities*. Under these standards, the rights, obligations and liability of the registered service provider and the individual must be set out in the individual

³⁹ Standard 7.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*, HIQA.

service agreement.⁴⁰ Under the English Domiciliary Care Standards, there is a requirement that each service user that finances the cost of care themselves must be provided with a written contract that must set out the various rights and responsibilities of both parties and their liability if there is a breach of contract or any damage occurring in the home.⁴¹ The Commission now turns to describe briefly the scope of these general obligations under employment law.

4.42 Under the *Terms of Employment (Information) Act 1994*, employers are obliged to provide a written statement of terms of employment within the first two months of the commencement of employment. The statement of terms of employment must include particular details including: the name and address of the employer and the employee; the place of work; the title or nature of the job; the method of payment; any terms and conditions in relation to hours of work, paid leave, sick leave; and any periods of notice for termination of the contract required.⁴² It should be noted that the provisions of the 1994 Act do not apply to those who are normally expected to work for less than 8 hours a week.⁴³

4.43 Under the *Organisation and Working Time Act 1997*, an employer may not require an employee to work more than an average of 48 hours in a week. This average is spread out over a minimum period of four months.⁴⁴ The *Organisation and Working Time Act 1997*, also sets out specific provisions in relation to holiday leave, which the service user must take into account.⁴⁵ The employer must provide the carer with a payslip, detailing the gross wage, and the amount of deductions.⁴⁶ Employers are also required to pay their employees a wage that does not fall below the agreed national minimum wage.⁴⁷ The employer is also responsible for the employee's income tax (PAYE) and social

⁴⁰ Standard 13.11 of the *National Quality Standards for Residential Services for People with Disabilities*.

⁴¹ Standard 4.2 of the *Domiciliary Care – National Minimum Standards*. A similar provision is made under standard 5.2 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*.

⁴² Section 3(1)(a) of the *Terms of Employment (Information) Act 1994*.

⁴³ Section 2(1)(a) of the *Terms of Employment (Information) Act 1994*.

⁴⁴ Section 15(1)(a) of the *Organisation and Working Time Act 1997*.

⁴⁵ Part III of the *Organisation and Working Time Act 1997*.

⁴⁶ Section 4(1) of the *Payment of Wages Act 1991*.

⁴⁷ Section 14(a) of the *National Minimum Wage Act 2000*.

insurance (PRSI).⁴⁸ The employer is also vicariously liable for any negligence by a carer employed by it.⁴⁹

(2) Safety and health responsibilities

4.44 The provision of domiciliary care services raises some safety and health concerns both for service users and home care workers. The *Safety, Health and Welfare at Work Act 2005* imposes general duties on employers to ensure, so far as is reasonably practicable, the safety, health and welfare of employees⁵⁰ and of persons other than employees who are present at a place of work.⁵¹ The 2005 Act also requires employers to have in place a written statement of safety management procedures, called the safety statement, including a requirement to specify how it has secured and managed the safety, health and welfare of employees⁵² and persons other than employees.⁵³ The general duties in the 2005 Act have been supplemented by a series of detailed Regulations setting out specific duties of employers, notably, the *Safety, Health and Welfare at Work (General Application) Regulations 2007*.⁵⁴

4.45 In addition to general issues concerning safety and health, the Commission is aware of some specific issues that arise in the context of professional carers in a domiciliary setting. Thus, there has been some debate as to whether it would be appropriate, on safety and health grounds, for an employer to prohibit carer employees from engaging in manual lifting of clients in their homes. In the English case *R. (A and B) v East Sussex County Council*,⁵⁵ the English High Court (Munby J) held that such a “no lift” ban would be in breach of the rights of the service user under the European Convention on Human Rights. In this case, two sisters A and B, who were profoundly disabled

⁴⁸ The Revenue Commissioners have published an information leaflet to assist domestic employers with their responsibilities for their employee’s tax. For more see “Domestic Employer Scheme – Employing a person in your home”, Reference Material IT 53, available at www.revenue.ie.

⁴⁹ See McMahon and Binchy, *The Law of Torts*, (3rd ed, Tottel Publishing, 2000), Ch 43, p1091-1117.

⁵⁰ Section 8 of the *Safety, Health and Welfare at Work Act 2005*.

⁵¹ Section 12 of the 2005 Act.

⁵² Section 20 of the 2005 Act.

⁵³ Section 20(9) of the 2005 Act.

⁵⁴ SI No. 299 of 2007.

⁵⁵ [2003] EWHC 167 (Admin) (High Court of England and Wales, 18 February 2003).

and suffered from learning difficulties, successfully applied (with the support of the British Disability Rights Commission) for a declaration that East Sussex County Council's (ESCC) virtual blanket "no manual lifting policy" was illegal. The sisters lived with their parents in a house which had been especially adapted. Under British legislation, they were entitled to care from the local authority. As a result of some incidents, A and B and their parents challenged the ESCC's policy of not permitting care staff to lift A and B manually.

4.46 Munby J held that it was not 'reasonably practicable' within the meaning of the British *Health and Safety at Work Act 1974* (the equivalent of the Irish 2005 Act) for the ESCC to avoid the need for their employees to undertake manual handling of A and B altogether. Munby J accepted that the ESCC's revised manual handling policy, which was presented to the Court after the case had begun and which made clear that it did not have a blanket no manual lifting policy, was lawful and "representative of good practice." It was therefore compatible with the British *Manual Handling Operations Regulations 1992*⁵⁶ and with the ECHR, which had been implemented in the UK by the *Human Rights Act 1998*.

4.47 Thus, the new policy of the ESCC shifted the dispute from being an issue about the lawfulness of the ESCC's alleged blanket no manual lifting policy, to being an issue about whether A and B were entitled to be manually lifted by their carers. Munby J held they were. He held that the British 1992 Regulations established a clear hierarchy of safety measures but were a risk reduction/minimisation regime and not "a no risk regime." There was, he noted, no "absolute prohibition on hazardous lifting." Rather, the employer's duty was to avoid or minimise the risk in so far as is reasonably practicable. In the case of A and B, and when considering the needs of those with a disability, the term reasonably practicable must, he said, take account of the rights of disabled persons in the ECHR. The reasonably practicable test must now, where the disabled are concerned "be informed" by the ECHR.

4.48 While this decision might not be followed precisely in Ireland, it is worth noting that Irish courts are also required to take account of the ECHR because it too has been implemented in Ireland by the *European Convention on Human Rights Act 2003*, which is modelled on the UK *Human Rights Act 1998*.

4.49 Turning to more general issues in this respect, the *National Quality Standards for Residential Care Settings for Older People*, require that the "rights, obligations and liability of the resident and the registered provider"⁵⁷ be

⁵⁶ The equivalent of Part 4, Chapter 4 of the *General Application Regulations 2007*.

⁵⁷ Standard 7.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

accounted for in the contract for service. The Standards also provide that the health and safety of the resident, staff and visitor are promoted and protected.⁵⁸ The registered provider is required to ensure that the care setting complies with all aspects of relevant health and safety legislation. The registered provider must ensure that there are policies and procedures in place for providing and maintaining a safe and healthy place of work.⁵⁹ Other jurisdictions which have set out standards for the domiciliary care sector, require that the responsibilities of the service user and of the agency regarding health and safety must be recorded in the contract for care.⁶⁰

4.50 The *National Quality Standards for Residential Care Settings for Older People*, require that the contract takes account of the liability of the resident and the registered provider.⁶¹ This is to cover against any loss or damage to the service user's assets, and the delivery of the service. The English Domiciliary Care Standards require that the contract for care between the parties sets out the various rights and responsibilities of both parties, including insurance, and liability if there is a breach of contract or any damage occurring within the home.⁶²

4.51 Having considered these aspects of the national standards and the specific issues identified in the English *A and B* case, the Commission has concluded that any contract for domiciliary care provision should make specific reference to the responsibilities that arise under employment law, including any specific issues arising under safety and health legislation.

4.52 *The Commission provisionally recommends that any contract for domiciliary care provision should make specific reference to the responsibilities*

⁵⁸ Standard 26 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁵⁹ Standard 26.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁶⁰ See Standard 4.2 of the English *Domiciliary Care – National Minimum Standards*, standard 5.2 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*, standard 4.2 of the Northern Irish *Domiciliary Care Agencies – Minimum Standards*.

⁶¹ Standard 7.2 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

⁶² Standard 4.2 of the *Domiciliary Care – National Minimum Standards*. The *National Minimum Standards for Domiciliary Care Agencies in Wales* make similar provisions under standard 5.2.

that arise under employment law, including any specific issues arising under safety and health legislation.

E Mental capacity and domiciliary care

4.53 The Commission now turns to discuss the issue of the mental capacity of the service user. Under the Government's *Scheme of a Mental Capacity Bill 2008*, which proposes to implement the key recommendations in the Commission's 2006 *Report on Vulnerable Adults and the Law*⁶³ a person over 18 years of age will be presumed to have full capacity to enter into contracts. In this respect, the Scheme of the Bill proposes a functional approach to determining capacity,⁶⁴ so that a person would be deemed to have capacity if he or she has cognitive understanding of a particular decision at the time the decision is to be made. The functional approach test accommodates the reality that decision-making capacity is a continuum rather than an end-point which can be neatly characterised as present or absent.⁶⁵ This approach recognises that legal capacity issues arise in a specific factual context such as the capacity to enter into a contract for care.⁶⁶ Therefore, the assessment of capacity should also be narrowed to the particular decision which needs to be made.

4.54 The Scheme of the Bill also proposes to establish an Office of Public Guardian (OPG). The functions of the OPG would include a supervisory role in respect of personal guardians and persons appointed under enduring powers of attorneys.⁶⁷ The OPG would also deal with representations including complaints about the way in which personal guardians exercise their powers.⁶⁸

(1) General authority to act on another's behalf

4.55 The Scheme of the Bill, in keeping with the Commission's recommendations, proposes that a person who makes a relatively minor decision with regard to the personal care, healthcare or treatment of another person whose decision-making capacity is in doubt should be protected from

⁶³ LRC 83-2006.

⁶⁴ Head 2 of the *Scheme of Mental Capacity Bill 2008*.

⁶⁵ *Report on Vulnerable Adults and the Law* (LRC 83-2006) at para 2.28.

⁶⁶ *Report on Vulnerable Adults and the Law* (LRC 83-2006) at para 2.27.

⁶⁷ Head 32(2) of the *Scheme of Mental Capacity Bill 2008*.

⁶⁸ Head 32(2)(i) of the *Scheme of Mental Capacity Bill 2008*. This role of the Public Guardian to deal with complaints was considered in more detail above, in Chapter 3.

civil and criminal liability.⁶⁹ This person must take reasonable steps to establish the other person's lack of capacity.⁷⁰ The Scheme of the Bill also proposes that where such a decision involves money and is carried out in the interest of an adult who is reasonably believed to lack capacity to consent, the person taking the action may lawfully apply the money in the possession of the person concerned for meeting his or her expenditure.⁷¹ Thus where this "general authority to act" is used, a person who acts as a representative of an individual who lacks capacity and enters into a contract for the provision of domiciliary care might not incur any liability in relation to the act. The representative may also reimburse himself or herself out of money in the other person's possession.⁷² The Commission considers that, in the context of domiciliary care, it may be appropriate that such a representative could refer his or her "general authority" decisions to the Office of Public Guardian. It would then be a matter for the OPG to determine whether the contract for care is an appropriate contract with regard to the individual's personal care needs. The OPG would also have to consider whether the decisions made by the representative constitute an appropriate expenditure of money.

(2) Personal guardian

4.56 The Commission acknowledges that the use of a "general authority" in this context may, however, be open to potential misuse, even where it is subject to the supervision of the OPG. Another option which could be considered where a person lacks the capacity to enter into a contract for care is the appointment of a personal guardian, as proposed under the Scheme of the 2008 Bill.⁷³ The personal guardian could be authorised to make decisions in relation to care including the authority to enter into contracts for care on behalf of the person who lacks capacity. Under the Scheme of the 2008 Bill, the Office of Public Guardian would have a supervisory and support role for all personal guardians appointed by a guardianship order,⁷⁴ and also attorneys operating under an enduring power of attorney.⁷⁵ The personal guardian could be obliged

⁶⁹ Head 16 of the *Scheme of Mental Capacity Bill 2008*.

⁷⁰ Head 16(2) of the *Scheme of Mental Capacity Bill 2008*.

⁷¹ Head 16(4) of the *Scheme of Mental Capacity Bill 2008*.

⁷² *Ibid* Section 8(3).

⁷³ Head 6(2)(b) of the *Scheme of Mental Capacity Bill 2008*. The appointment of a personal guardian for a person who lacks capacity was a recommendation of the Commission in its *Report on Vulnerable Adults*.

⁷⁴ Head 32(2)(d) of the *Scheme of Mental Capacity Bill 2008*.

⁷⁵ As shall be discussed in more detail below.

to give a report on the welfare of the person lacking capacity and an account of the property, income and expenditure to the Office of Public Guardian.⁷⁶

(3) Enduring power of attorney

4.57 A third option available in cases where a person lacks the capacity to enter into a contract for care arises where an enduring power of attorney (“EPA”) has been executed. An enduring power of attorney is a legal mechanism executed by the individual concerned when he or she has the requisite capacity. The EPA confers on a nominated attorney certain decision-making powers, in the event that the individual loses capacity.⁷⁷ Once a person who has made an EPA loses capacity then his or her attorney can make decisions relating to his or her property or affairs and/or “personal care” decisions. Currently, a “personal care” decision does not give an attorney any authority to make any health care decisions. However, the *Scheme of the Mental Capacity Bill 2008* proposes that “welfare” decisions could include decisions on health care⁷⁸.

4.58 Under the Scheme of the Bill, the Office of Public Guardian would play a supervisory and support role for all attorneys operating under an EPA. The OPG would also have the power to deal with representations, including complaints, about the way in which an attorney operating under an enduring power of attorney is exercising his or her powers.⁷⁹

(4) Conclusion

4.59 *The Commission invites submissions on whether it is appropriate that, in connection with an individual whose capacity to enter into a contract is in doubt or may be absent, a “general authority” to act on the person’s behalf could include entering into a contract for the provision of domiciliary care or whether this should be a matter only for a personal guardian or an attorney appointed under an enduring power of attorney.*

⁷⁶ Head 32(2)(j) of the *Scheme of Mental Capacity Bill 2008*.

⁷⁷ See generally Gallagher *Powers of Attorney Act 1996* (Round Hall Sweet & Maxwell 1998). Law Reform Commission *Report on Vulnerable Adults and the Law* (LRC 83-2006) Chapter 4.

⁷⁸ Head 48(3) of the *Scheme of Mental Capacity Bill 2008*.

⁷⁹ Head 32 of the *Scheme of Mental Capacity Bill 2008*.

CHAPTER 5 PROTECTIVE MEASURES

A Introduction

5.01 In this Chapter, the Commission examines a number of protective measures to ensure high standards of selection are in place for professional carers and to maximise the protection of service recipients. In Part B, the Commission examines the procedures currently in place in Ireland for screening in the context of sensitive positions of responsibility and the recommendations made in the 2004 *Report of the Working Group on Garda Vetting*. In Part C the Commission examines the different protection mechanisms adopted in other jurisdictions, notably the approach in the United Kingdom between the devolved administrations (in Northern Ireland and Scotland) and England and Wales. In Part D, the Commission examines the safeguards afforded to those who report abuse of vulnerable people (whistleblowers).

B Current screening and vetting arrangements for sensitive posts

5.02 It is essential that all domiciliary care providers, whether in the public sector or private sector, ensure that their professional carers have suitable competence (including relevant training and experience) in the context of the sensitive work in which they are engaged. This should include recruitment processes that involve screening and vetting arrangements to maximise the high quality of care that the Commission understands is the norm. Such screening must also prevent unsuitable persons from becoming professional carers, in particular, that those whose behaviour could be a threat to the safety and well-being of vulnerable adults are not employed in care positions. The Commission now turns to examine the current screening procedures for those who wish to work with vulnerable adults.

5.03 The Commission in its 2007 *Report on Spent Convictions*¹ examined the issue of vetting procedures in Ireland in the context of spent convictions. “Vetting” is the process by which a potential employee agrees to have a background check carried out on them by official authorities.² The aim of this

¹ Law Reform Commission *Report on Spent Convictions* (LRC Report 84-2007) at Chapter 4.

² *Ibid* at paragraph 4.03.

background check is to provide certain information to the potential employer enabling them to screen candidates in order to determine the suitability of the person concerned for the job. The result of this screening procedure is to minimise the potential risk to vulnerable members of society from contact with individuals whose behaviour could be detrimental to their safety and well-being. While the vast majority of people who apply to work with vulnerable adults are likely to be of good character, it is nevertheless essential that organisations that provide care to vulnerable adults take all reasonable steps to ensure that only suitable persons are employed in care positions.³

5.04 An Garda Síochána plays a significant role in promoting the welfare and protection of vulnerable adults through the Garda Central Vetting Unit (GCVU). The GCVU was established in 2002 on an administrative basis,⁴ for the purpose of dealing with requests for criminal record vetting. The GCVU does not provide clearance for persons to work with vulnerable adults, but rather it discloses details regarding all prosecutions, pending or completed, and/or convictions. Initially, the GCVU focused primarily on vetting in the health and social services sector. In 2006, the GCVU began a phased expansion to include the vetting of all persons who would have substantial, unsupervised access to children and vulnerable adults, regardless of whether they worked full-time or part-time. Under the current system, the GCVU deals with requests to screen or vet certain prospective employees of the HSE and agencies funded by the HSE where the work involves access to children and vulnerable adults,⁵ as well as new teachers, staff working in the youth work sector, and staff working in care homes for older people. This scope has been extended to include private hospitals, residential childcare centres, and agencies working with the homeless, local community initiatives, arts organisations and private tuition centres. Where such a request is made, the GCVU completes a criminal history check on the potential employees, by using the Garda Criminal Records Office (GCRO) Criminal Registry System and the PULSE system.⁶ The results of the search are then sent to the designated agency that makes the request, which then makes the decision whether or not to employ the person in question.

³ Section 3.2.2 of the *Report of the Working Group on Garda Vetting* (2004) available at www.justice.ie.

⁴ The 2004 *Report of the Working Group on Garda Vetting* recommended that the GCVU be placed on a clear statutory setting. In its 2007 *Report on Spent Convictions* the Commission fully supported this recommendation.

⁵ In many instances, a vetting policy has been a requirement for those organisations which are in receipt of funding through the HSE, and other state departments.

⁶ PULSE is an acronym for Police Using Leading Systems Effectively.

It is important to note in this respect that the existence of a criminal record (especially for relatively minor matters) does not, and should not, automatically prevent a person from gaining employment: the purpose of the screening and vetting process is to ensure that a prospective employer has all the relevant information available on which to make an informed judgement on the suitability of the job applicant.

5.05 The 2004 *Report of the Working Group on Garda Vetting* recommended the introduction of a three-tier system for recruitment and selection vetting. The Report recommended that a “special” level of vetting be introduced, that would be applicable to those applying for posts that involve substantial unsupervised access to children and vulnerable adults. A second “standard” level of vetting applicable to posts within public service and the private security sector and a final “security” level of vetting that would apply to those applying for posts that involve national security.⁷ There is a responsibility on employers who receive sensitive information to utilise that information in an appropriate and fair manner with regard to the prospective employee or volunteer as well as the vulnerable adult. The Working Group recommended that the disclosure of sensitive information should occur only with the written consent of the individual applicant.

5.06 In its 2007 *Report on Spent Convictions*, the Commission recognised that some employers, who would not ordinarily come under the description of a “designated agency”, were using alternative methods to retrieve personal data about potential employees. Under section 4(1) of the *Data Protection Act 1988*, any person may request a copy of ‘data’ about the person that is held by a ‘data controller’.⁸ Some employers were advising prospective employees to make a request under section 4 of the 1988 Act to the GCVU, without indicating the true purpose.⁹ This practice has been referred to as “enforced subject access”. The Commission supported the concerns expressed by the Data Protection Commissioner in relation to this misuse of section 4 of the 1988 Act by some employers.¹⁰ Section 5(d) of the *Data Protection (Amendment) Act 2003* proposes to amend section 4 of the 1988 Act, by providing that no person shall,

⁷ Section 3.4 of the *Report of the Working Group on Garda Vetting*.

⁸ The term “data” is defined as information in a form in which it can be processed, and “data controller” is defined as a person who, either alone or with others, controls the contents and use of personal data, as per section 1 of the *Data Protection Act 1988*.

⁹ Section 7.5.4 of the *Report of the Working Group on Garda Vetting*.

¹⁰ Law Reform Commission *Report on Spent Convictions* (LRC 84-2007) at paragraph 4.33.

in connection to the recruitment of another as an employee, the continued employment of that other or a contract for the provision of services to him or her by another person, require another to make a request under section 4(1) of the 1988 Act. At the time of writing (July 2009), section 5(d) of the 2003 Act has not yet been brought into force by a Commencement Order.

(1) “Soft” information

5.07 The Working Group on Garda Vetting recommended that “soft” as well as “hard” information should be disclosed through the vetting process. Such soft information would include allegations of a criminal nature in certain circumstances.¹¹ The 2006 *Report of the Joint Oireachtas Committee on Child Protection*¹² recommended that further research be conducted into the possibility of incorporating soft information into a comprehensive vetting system.¹³ The Joint Committee did not consider that the constitutional protection of the good name of the citizen was an insurmountable obstacle to the incorporation of soft information into the vetting process.¹⁴ The Committee considered that the Constitution does not prohibit procedures which can lead to findings adverse to a particular individual and to the publication of those findings to the detriment of that individual and his good name.¹⁵ The Joint Committee also noted, however, that the Constitution requires that the good name of the individual be protected from unjust attack, and in the case of injustice done, that the State, by its laws, should vindicate the good name of the citizen.¹⁶ The issue of requiring a constitutional amendment to deal with this matter definitively remains a live, and unresolved, issue at the time of writing (July 2009). The Commission also notes that the 2004 *Report of the Working Group on Garda Vetting* also recommended that vetting should provide for the disclosure of all criminal convictions, all past criminal prosecutions, all criminal prosecutions pending and allegations and complaints involving alleged criminal activity and limited to a case-by-case basis, even where the DPP is considering whether a relevant prosecution should be brought.

¹¹ Section 3.3 of the *Report of the Working Group on Garda Vetting*.

¹² Joint Committee on Child Protection *Report on Child Protection*, (House of the Oireachtas, Government Publications, November 2006) available at www.oireachtas.ie

¹³ *Report on Child Protection* at section 15.3.4.

¹⁴ *Report on Child Protection* at section 15.3.3.

¹⁵ *Report on Child Protection* at section 15.3.4.

¹⁶ *Ibid.*

5.08 In general, soft information includes allegations of a criminal nature. It is clear that this is, therefore, a matter that raises many constitutional issues, as the Report of the Oireachtas Committee makes clear. As this is a matter which may ultimately require a constitutional amendment, and which is currently (July 2009) still under consideration, the Commission does not consider it appropriate to make any recommendations on the issue of whether soft information should be included in any screening or vetting process concerning professional domiciliary carers.

(2) Abuse of vulnerable adults and elder abuse

5.09 As already mentioned in Chapter 1, people who receive care at home are in a vulnerable position, and are at risk of abuse from those who hold positions of power over them. Such vulnerable adults may not always be in a position to complain about ill treatment or report abuse. The nature of the abuse may also make vulnerable adults reluctant to complain or report abuse. Such people are often reluctant to complain or report abuse for various reasons. Vulnerable adults need to be protected by ensuring that there are procedures in place to enable them and others to report suspected abuse, and for these complaints to be fully investigated without fear adverse consequences and/or repercussions.

5.10 There are many profiles of perpetrators of abuse against vulnerable adults, and the abuse can occur in many different situations. The following are some hypothetical examples of how unregulated professional carers might exploit their position of power over a vulnerable adult:

- use of psychological and/or physical abuse to gain control over the vulnerable adult;
- financially abusing a vulnerable adult, whereby the professional carer is in possession of the vulnerable adult's pension book, for the purpose of collecting the pension. The carer may be directed to use the pension money to pay for services and/or items that the vulnerable adult needs, and there is a risk that a carer could misappropriate the proceeds for their own benefit;
- use of physical and/or sexual abuse or the threat of such abuse to cause the vulnerable adult to submit to their requests, or to cause the vulnerable adult not to complain of any mistreatment;
- neglect of a vulnerable adult, by failing to provide an appropriate level of care, for example by not providing personal care, or neglecting any medical or personal care needs the vulnerable adult may have, or allowing the vulnerable adult to develop bed sores;

- the use of medications, particularly of anti-psychotic medication for people with dementia, to control or manage difficult vulnerable adults;
- use of emotional abuse, to extort money or personal items from the vulnerable adult in exchange for completing tasks that the carer is already being paid to do.

5.11 In recent years, the issue of abuse of older persons or “elder abuse” has received increased attention from government agencies, the media and the public at large. The term “elder abuse” has been defined as:

“A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person or violates their human or civil rights.”¹⁷

The HSE has taken significant measures in recent years to combat elder abuse in particular by raising awareness about the issue.¹⁸ As part of these measures, the HSE have appointed Dedicated Officers for Elder Abuse in each HSE administrative area. These Officers are responsible for developing and evaluating the HSE’s response to elder abuse. The HSE has also appointed Senior Care Workers for Elder Abuse, who are employed within Local Health Offices, and who work closely with Dedicated Officers for Elder Abuse to assess and manage cases of suspected elder abuse referred to the HSE. These initiatives have led to increased public awareness of elder abuse, and increased reporting of incidents of suspected elder abuse. Of the total number of cases of alleged abuse reported to the HSE in 2008, over 85% of them concerned incidents of abuse within the victim’s own home.¹⁹ This can be compared to just 4% of reported cases relating to abuse occurring within private residential care units. This comparatively low rate of abuse in residential care settings may be attributable to the recent developments in the regulation of the residential care

¹⁷ Report of the Working Group on Elder Abuse *Protecting Our Future* (Stationery Office, Dublin, 2002) at p25. This definition of elder abuse was endorsed by the HSE in the National Elder Abuse Steering Committee *HSE Elder Abuse Service Developments 2008: Open Your Eyes 2008*, at p.5, available at www.hse.ie.

¹⁸ The National Centre for the Protection of Older People is currently (July 2009) undertaking a programme of research which examines the issue of elder abuse in Ireland. This programme is funded by the HSE and consists of a collaborative research team from various schools within University College Dublin. The aim of the centre’s research is to contribute to the development of policy and practice in relation to elder abuse. See www.ncpop.ie.

¹⁹ National Elder Abuse Steering Committee *HSE Elder Abuse Service Developments 2008: Open Your Eyes 2008* at p27.

sector. This contrast between the levels of reported abuse in the different care settings further highlights the need for the domiciliary care sector to be regulated.

5.12 Under the *National Quality Standards for Residential Care Settings for Older People in Ireland*, residential care providers are required to establish a policy in relation to the prevention of, and the reaction to, all forms of abuse.²⁰ This policy must outline the procedures for preventing, detecting and responding to suspicion, allegation or evidence of abuse or neglect.²¹ All staff are required to be trained in the procedures for preventing and responding to abuse.²² The Standards do not require either the care contract or the resident's care plan to take account of these procedures and policies.

5.13 The relevant legislation and standards in other States require domiciliary care providers to establish procedures and policies for dealing with cases and/or suspected cases of abuse.²³ The Standards do not require the care contract or the service user care plan to take account of these procedures and policies.²⁴ Due to the vulnerable position that people who receive home care are in and the extent to which they are dependent on the home care worker, it is important that measures are taken to ensure that home care workers possess the requisite competence and skills to provide the care.

5.14 Head 27 of the Government's *Scheme of Mental Capacity Bill 2008*,²⁵ proposes to introduce a new criminal offence of ill treatment or wilful neglect, based on a similar offence in section 44 of the English *Mental Capacity Act 2005*. Three categories of persons are dealt with in Head 27 (and in section 44 of the English 2005 Act): a person "who has the care of another person who lacks, or whom the [carer] reasonably believes to lack, capacity;" a person appointed as an attorney under an enduring power of attorney; and a person appointed under the Scheme of the Bill as a personal guardian. It is clear that a professional carer who provides domiciliary care could come within Head 27 of

²⁰ Standard 8 of the *National Quality Standards for Residential Care Settings for Older People in Ireland*, HIQA.

²¹ Standard 8.1.

²² Standard 8.4.

²³ Regulation 14(6)(a) of the *Domiciliary Care Agencies Regulations 2002*.

²⁴ See Standards 4.2, 7 and 14 of the *English Domiciliary Care – National Minimum Standards*; Standards 4, 5.2 and 14 of the *National Minimum Standards for Domiciliary Care Agencies in Wales*; Standards 2 and 3 of the *Scottish National Care Standards – Care at Home*.

²⁵ See paragraph 2 of the Introduction to the Consultation Paper.

the Scheme of the 2008 Bill because he or she has responsibility for the care of another who lacks capacity. Under the Scheme of the Bill, a person found guilty of the offence of ill treatment or wilful neglect would, on summary conviction, be liable to a term of up to 12 months imprisonment, or a fine not exceeding €3000, or both. On conviction on indictment, a person found guilty of the offence would, be liable to up to 5 years imprisonment, or a fine of €50,000 or both.²⁶ The Commission endorses the proposal in Head 27 of the Government's Scheme of Mental Capacity Bill 2008 to create an offence of ill treatment or wilful neglect as involving an important protective element in the context of domiciliary care.

5.15 *The Commission endorses the proposal in head 27 of the Government's Scheme of Mental Capacity Bill 2008 to create an offence of ill treatment or wilful neglect as involving an important protective element in the context of domiciliary care.*

C Whistle-blowing protection and protected disclosures

5.16 In this Part, the Commission discusses the position of a person who discloses information to the relevant authorities about serious concerns they may have about a health or social care service which either they or someone they are in contact with, are receiving. Such a "whistleblower" may also be someone who is employed by a health or social care provider, and who discloses information to the relevant authority about the care provider. This Part also discusses the distinction between the protective measures offered to those who report child abuse and those who report abuse of vulnerable adults.

(1) Protection for Persons Reporting Child Abuse Act 1998

5.17 The *Protection for Persons Reporting Child Abuse Act 1998* introduced legal safeguards to protect persons who reported concerns about incidents of possible child abuse. Section 3(1) of the 1998 Act provides that where a person expresses his or her opinion to an appropriate person that a child is or has been abused²⁷ he or she will not be liable for damages, provided that he or she acts reasonably and in good faith.

5.18 The 1998 Act provides that where an employee makes a communication under section 3, his or her employer shall not penalise the

²⁶ Head 27(2)(a)-(b) of the *Scheme of Mental Capacity Bill 2008*.

²⁷ Section 3(1)(a) of the *Protection for Persons Reporting Child Abuse Act 1998* includes where a child has been or is being assaulted, ill-treated, neglected or sexually abused. Section 3(1)(b) covers the expression of opinions that a child's health, development or welfare has been or is being avoidably impaired or neglected, (as per section 3(1)(b)).

employee for having done so.²⁸ Where an employer breaches this provision, the employee may present a complaint to a rights commissioner in the Labour Relations Commission that his or her employer has contravened this provision, and the rights commissioner must give the parties an opportunity to be heard by the commissioner. Where a person makes a statement in accordance with section 3, and he or she knows the statement to be false, that person shall be guilty of an offence.²⁹

5.19 The 2004 *Report of the Working Group on Garda Vetting* recommended that the *Protection of Persons Reporting Child Abuse Act 1998* should be amended so as to offer protection for persons reporting the abuse of vulnerable adults, such as those with certain mental or physical disabilities.³⁰ The Commission considers that this proposal is worthy of further consideration and has concluded that it should invite submissions on the issue of protecting people who report concerns about incidents of possible abuse of vulnerable adults, by professional carers.

5.20 *The Commission invites submissions as to whether the form of protection for people who report concerns about incidents of possible abuse contained in the Protection of Persons Reporting Child Abuse Act 1998 should be extended to apply in the context of professional domiciliary care.*

(2) Protected disclosure in relation to the care of vulnerable adults

5.21 A recipient of domiciliary care is often in a vulnerable and isolated position which makes it difficult for them to disclose information about a serious concern he or she may have about the standard of safety or quality of the service that he or she is receiving. It is also possible that the service recipient will not want to make a complaint about the provision of service for fear that the service will be removed from them, or that the abuse will worsen or that he or she will be open to civil legal action. A situation could also arise whereby the service recipient is not aware that there is anything untoward about the safety or quality of the service being provided. In such situations, there is a danger that such incidents of abuse can go unreported. In many situations, vulnerable service recipients rely on others to make complaints or to disclose information

²⁸ Section 4(1) of the *Protection of Persons Reporting Child Abuse Act 1998*.

²⁹ On summary conviction, a person shall be liable to a fine not exceeding £1,500 or a term of imprisonment not exceeding 12 months or to both. On conviction on indictment, a person shall be liable to a fine not exceeding £15,000 or a term of imprisonment not exceeding 3 years, or to both, as per section 5(2) of the 1998 Act.

³⁰ *Report of the Working Party on Garda Vetting* available at www.justice.ie at para 5.2.3.

to the relevant authority on his or her behalf. A person who makes a disclosure of information in this regard is known as a whistleblower and could be a relative, a friend or a neighbour.

5.22 The *Protection of Persons Reporting Child Abuse Act 1998* was introduced to protect people who report child abuse from civil liability. The 1998 Act provides that where an employee makes a communication under section 3, then he or she must not be penalised for so doing.³¹ If a person knowingly makes a false statement under section 3, then he or she shall be guilty of an offence under section 5.

5.23 The *Health Act 2004* (which established the Health Service Executive), as amended by the *Health Act 2007*, has made extensive provision in relation to employees of relevant bodies who make disclosures of information.³² Where an employee of a relevant body³³ makes a disclosure of information to an authorised person in good faith, then this disclosure shall be deemed to be a “protected disclosure”.³⁴ Such a disclosure of information must be made in good faith, and the whistleblower must believe on reasonable grounds that the disclosed information will establish that the health or welfare of a person who is receiving a health or personal social service is or is likely to be at risk,³⁵ that the actions of any person employed by a relevant body poses or is likely to pose a risk to the health or welfare of the public³⁶ or that the relevant

³¹ Section 4 of the *Protection of Persons Reporting Child Abuse Act 1998*.

³² Section 103(1) of the *Health Act 2007* amended the *Health Act 2004* by inserting Part 9A into the 2004 Act. Section 55B of the 2004 Act, now provides for the protected disclosure of information by an employee of a relevant body. Sections 55E and 55G make further provisions regarding protected disclosures of information in relation to regulated professions by persons other than employees.

³³ Section 55A of the *Health Act 2004* provides that a “relevant body” includes (a) the Executive (b) a service provider (c) any other person who has received or is receiving assistance in accordance with section 39 of the *Health Act 2004* or section 10 of the *Child Care Act 1991* and (d) a body established under the *Health (Corporate Bodies) Act 1961*. Under section 2 of the *Health Act 2004* a “service provider” is a person who enters into an arrangement with the HSE to provide a health or personal social service on behalf of the HSE. Thus, voluntary organisations that provide domiciliary care and private domiciliary care agencies and who enter into an arrangement with the HSE to provide the care on behalf of the HSE would be subject to section 55B of the *Health Act 2004*.

³⁴ Section 55B of the *Health Act 2004*.

³⁵ Section 55B(a) of the *Health Act 2004*.

³⁶ Section 55B(b) of the *Health Act 2004*.

body is failing or is likely to fail to comply with any legal obligation.³⁷ Where an employee makes a protected disclosure regarding the conduct of his/her employer, he or she shall not be penalised,³⁸ and any contravention of this by the employer constitutes a ground of complaint by an employee to a rights commissioner.³⁹

5.24 Where a person makes a protected disclosure, he or she is not liable in damages, or other forms of relief,⁴⁰ unless he or she knew that it was, or was reckless as to whether it was, false, misleading, frivolous or vexatious.⁴¹ Where a professional carer is employed by the HSE, or another organisation that has entered into an arrangement with the HSE to provide domiciliary care on behalf of the HSE,⁴² and he or she makes a disclosure of information on reasonable grounds and in good faith, the disclosure will be deemed to be protected.⁴³

5.25 Section 55C of the *Health Act 2004*, inserted by the *Health Act 2007*, appears to protect employees of residential institutions and private nursing homes not operated by the HSE or contracted to provide services on behalf of the HSE from liability for disclosing information to the chief inspector. This is the case where the information is disclosed in good faith and on reasonable grounds that it would show that (a) the actions of any person employed by the institution posed, is posing or is likely to pose a risk to the health or welfare of a resident or (b) the person carrying on the business has failed to comply with the regulations and standards as prescribed under the *Health Act 2004*, as amended by the *Health Act 2007*.⁴⁴

5.26 The *Health Act 2004*, as amended by the 2007 Act, does not specify whether the safeguards associated with a protected disclosure apply to an employee of a private domiciliary care agency, a voluntary organisation providing domiciliary care and/or a professional carer employed on an individual

³⁷ Section 55B(c) of the *Health Act 2004*.

³⁸ Section 55M(1) of the *Health Act 2004*.

³⁹ Section 55M(2) of the *Health Act 2004*.

⁴⁰ Section 55L(3) of the *Health Act 2004*.

⁴¹ Section 55L(2) of the *Health Act 2004*.

⁴² Section 38 of the *Health Act 2004*.

⁴³ Section 55B of the *Health Act 2004*.

⁴⁴ Section 55C of the *Health Act 2004* has not yet come into effect. It is expected that section 55C will come into effect in July 2009, when the Chief Inspector of Social Services commences the registration and inspection of the different elements of the social care services.

basis, where such a person makes a disclosure on reasonable grounds in the belief that it will satisfy section 55B of the Act.

5.27 There is now extensive legislation to safeguard employees who make protected disclosures and to protect individuals who report child abuse. However, there are no legal safeguards available to individuals who disclose information about a serious concern that they may have about the provision of domiciliary care to a relative, friend or a neighbour. Vulnerable adults who receive domiciliary care may not always be in a position to alert the relevant authority about concerns they may have about the provision of care. In this respect, the Commission considers that there should be some legal protection for people who disclose information on their behalf. These legal safeguards could be implemented by amending Part 9A of the *Health Act 2004*, in a way that ensures that such disclosures of information would be considered to be protected disclosures under the 2004 Act. This would ensure that where a person discloses information in good faith about suspected abuse of vulnerable adults, the disclosure will be a protected disclosure and the person disclosing the information will not be civilly liable for making the disclosure.

5.28 *The Commission provisionally recommends that Part 9A of the Health Act 2004, which deals with disclosure of abuse, be amended, to ensure that employees of domiciliary care providers will be covered by the protected disclosure safeguards.*

(3) Other jurisdictions

5.29 Under the relevant legislation in England and Wales, and Northern Ireland and Scotland, no person can take proceedings because of the fact that he or she is listed, or that information has been provided to the relevant authority about the individual in accordance with the relevant legislation.

5.30 Under the *Safeguarding Vulnerable Groups Act 2006*, where a person provides information to the Independent Safeguarding Authority (ISA) in accordance with the 2006 Act, no action for damages can be taken against him or her.⁴⁵ However, if such a person provides information which he or she knows to be untrue then the individual cannot rely on the civil legal safeguards mentioned.⁴⁶ The *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007* makes similar provisions in relation to the protection of persons who refer information to the ISA.⁴⁷ The *Protection of Vulnerable Groups (Scotland) Act 2007* provides more detailed civil legal protection for those who provide

⁴⁵ Section 57 of the *Safeguarding Vulnerable Groups Act 2006*.

⁴⁶ Section 57(2) of the *Safeguarding Vulnerable Groups Act 2006*.

⁴⁷ Section 57 of the 2007 Order.

information to the Scottish Ministers in accordance with sections 3 to 8 of the 2007 Act. Where a person provides information to the Ministers, he or she will not be liable for any loss or damage incurred by any person. However, where the provider of information knew, or was reckless as to whether the information being provided was untrue or misleading, and he or she still provided that information knowing that it could be used by the Ministers in their decision to include someone on a barred list, then that person shall not escape legal liability.⁴⁸

D Safeguards in other jurisdictions

5.31 In this Part, the Commission examines the measures in place in other jurisdictions for the protection of vulnerable adults. In England, Wales and Northern Ireland there have been significant legislative developments in recent years in relation to the screening and monitoring of those who provide care to vulnerable adults. In those jurisdictions, there is a far-reaching system which includes the establishment of negative registers and the use of “soft” information in the screening process. These protection mechanisms are discussed in detail. A separate but aligned scheme is currently being established in Scotland, under the *Protection of Vulnerable Groups (Scotland) Act 2007*. The relationship between the protection mechanisms in place in each of these jurisdictions is also discussed. The issue of mandatory reporting of abuse is also discussed. In this regard, the situation in Australia shall be examined. In Australia, the legislation confers on approved care providers an obligation to report incidents of abuse or suspected abuse. This mandatory reporting obligation does not, however, extend to members of the public. Legislation in place in the Canadian province of Alberta also confers a mandatory obligation to report abuse on any person who has a reasonable belief that the recipient of a care service is being abused. In British Columbia, legislation imposes a voluntary reporting system.

(1) England and Wales

5.32 In England and Wales, the *Care Standards Act 2000* introduced significant measures in relation to the protection of children and vulnerable adults. Part VII of the 2000 Act provided for the establishment of a type of ‘negative register’ – a list of individuals who were considered unsuitable to work with vulnerable adults.⁴⁹ This list was known as the Protection of Vulnerable Adults list (POVA list). Under the 2000 Act, a provider of care for vulnerable adults had the duty to refer any person, who had been dismissed on grounds of

⁴⁸ As per section 41(2) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

⁴⁹ Section 81(1) of the *Care Standard Act 2000*.

misconduct, or who had resigned in circumstances such that the provider would have dismissed him, to the Secretary of State for Health.⁵⁰ Once the Secretary of State received such information, he or she provisionally placed the worker on the POVA list.⁵¹ The Secretary of State was required to invite observations from the worker on the information submitted to him by the employer. However, the Secretary of State was not required to do this before the worker was provisionally included in the list. After considering all the information presented, the Secretary of State then decided whether the provider reasonably considered whether the individual was guilty of misconduct and whether he or she was unsuitable to work with vulnerable adults. Thus the test was not whether the misconduct actually took place, but rather whether the employer reasonably considered that it did.⁵² On a practical note, there were considerable time delays between the initial referral to the Secretary of State and the final determination about an individual's inclusion in the POVA list. It appears that about 80% of referrals to the Secretary of State were not confirmed on the list.⁵³ The effect of being provisionally included on the list prevented any other employer from employing the individual in a care position.⁵⁴ The appellants in *R (Wright) v. Secretary of State for Health* contended that the *Care Standards Act 2000* was incompatible with Articles 6 and 8 of the *European Convention on Human Rights* by virtue of the lack of an opportunity to have an oral hearing before being provisionally listed on the POVA list. The House of Lords agreed and found that the procedure for provisional listing did not meet the requirements of Article 6(1). It is worth noting that all Law Lords agreed that the principle in the 2000 Act of providing protective measures through screening was appropriate in the context of vulnerable persons; the fatal flaw with the 2000 Act was in terms of the effect on employment of a provisional listing.

5.33 The *Safeguarding Vulnerable Groups Act 2006* established the Independent Barring Board⁵⁵ to create and maintain the children's barred list

⁵⁰ Section 82(1) of the *Care Standard Act 2000*.

⁵¹ Section 82(4)(b) of the *Care Standard Act 2000*.

⁵² As per Baroness Hale of Richmond in *R (Wright and others) v Secretary of State for Health* [2009] UKHL 3 at paragraph 8.

⁵³ *R (Wright) v Secretary of State* [2009] UKHL 3 at paragraph 9.

⁵⁴ *Ibid* at paragraph 12.

⁵⁵ Section 1 of the *Safeguarding Vulnerable Groups Act 2006* established the Independent Barring Board, which is in the process of being replaced by the Independent Safeguarding Authority. The Authority is due to appoint its CEO in September 2009, and until then the barred lists will remain in operation.

and the adults' barred list.⁵⁶ A person will be barred from regulated activity⁵⁷ relating to vulnerable adults,⁵⁸ where he or she is included on the adults' barred list or is included in a list maintained under the law of Scotland or Northern Ireland.⁵⁹ A person must be included on the adults' barred list if he or she engages in relevant conduct, which can include conduct which endangers⁶⁰ or is likely to endanger a vulnerable adult,⁶¹ inappropriate conduct involving sexually explicit images depicting violence against human beings⁶² and inappropriate conduct of a sexual nature involving a vulnerable adult.⁶³ It should be noted that the *Safeguarding Vulnerable Groups Act 2006* does not apply to informal carer arrangements.⁶⁴ The IBB must give the person in question the opportunity to

⁵⁶ Section 2 of the *Safeguarding Vulnerable Groups Act 2006*. However, it should be noted that the Independent Barring Board is to be replaced by the Independent Safeguarding Authority by October 2009.

⁵⁷ A "regulated activity" is defined in Section 7 of Part 2 of Schedule 4 of the *Safeguarding Vulnerable Groups Act 2006*. A regulated activity is one of the following that is carried out frequently by the same person: (a) any form of teaching of vulnerable adults (b) any form of care for or supervision of vulnerable adults (c) any form of assistance or guidance provided to a vulnerable adult or (d) any form of treatment or therapy provided for a vulnerable adult. Section 7(4) also provides that any activity carried out in a care home, will constitute a regulated activity for the purposes of section 3(3) of the *Safeguarding Vulnerable Groups Act 2006*.

⁵⁸ A vulnerable adult was defined as including a person who has reached the age of 18 and is in receipt of domiciliary care, which is defined as care of any description provided to an individual in their own home, by reason of their age, health or disability, as per section 59(1)(c) of the *Safeguarding Vulnerable Groups Act 2006*.

⁵⁹ Section 3(3) of the *Safeguarding Vulnerable Groups Act 2006*.

⁶⁰ A person's conduct endangers a vulnerable adult if he or she harms or attempts to harm a vulnerable, or causes a vulnerable adult to be harmed, as per Section 10(2) of Part 2 of Schedule 3 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶¹ Paragraph 10(1)(a) of Part 2 of Schedule 3 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶² Paragraph 10(1)(d) of Part 2 of Schedule 3 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶³ Paragraph 10(1)(e) of Part 2 of Schedule 3 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶⁴ Section 58 of the *Safeguarding Vulnerable Groups Act 2006*.

make representations as to why he or she should not be included in the adults' barred list.⁶⁵ A person who is included in a barred list may apply to the IBB for a review of his or her inclusion.⁶⁶ An individual who is included in a barred list may appeal to a Tribunal against a decision to include him or her in a barred list, but only on the grounds that the IBB made a mistake as to a point of law, or as to a finding of fact.⁶⁷ If the tribunal finds that the IBB has made a mistake, then it must direct the IBB to remove the individual from the list, and remit the matter to the IBB for a new decision.⁶⁸

5.34 A person is considered to be a regulated activity provider if he or she carries on a scheme under which an individual agrees with him or her to provide care or support to the individual who needs it and the provider is required to register with the Commission for Social Care Inspection.⁶⁹ It is important to note that a person is not considered to be a regulated activity provider if he or she is an individual and he or she enters into a private arrangement to provide care to another. An arrangement is considered to be a private arrangement if it is for the benefit of a child or vulnerable adult who is (a) a member of the provider's family, or (b) a friend of the provider.⁷⁰ It would appear that persons employed by domiciliary care agencies are subject to the provisions of the *Safeguarding Vulnerable Adults Act 2006*,⁷¹ but would seem that individuals who enter into a private arrangement with a family member or friend, to provide them with domiciliary care, are not subject to the provisions of the 2006 Act.⁷²

5.35 Under the *Safeguarding Vulnerable Groups Act 2006*, the Secretary of State for Health has a responsibility to provide any relevant information relating to a person who makes an application for the information in relation to another person. The person requesting the information must have the consent

⁶⁵ Paragraph 11(2) of Part 2 of Schedule 3 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶⁶ Paragraph 18(1) of Part 2 of Schedule 3 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶⁷ Section 4 of the *Safeguarding Vulnerable Groups Act 2006*.

⁶⁸ Section 4(6)(a) and (b) of the *Safeguarding Vulnerable Groups Act 2006*.

⁶⁹ As per section 11(1) of the *Care Standards Act 2000*.

⁷⁰ Section 6(7) of the *Safeguarding Vulnerable Groups Act 2006*.

⁷¹ Section 7(1)(b) of Part 2 of Schedule 4 of the *Safeguarding Vulnerable Groups Act 2006*, provides that a regulated activity includes any form of care for, or supervision of a vulnerable adult, by the same person.

⁷² Section 58 of the *Safeguarding Vulnerable Groups Act 2006*.

of that other person, about whom the information is concerned.⁷³ People who are entitled to make an application for vetting information include people who are considering employing another person to engage in a regulated activity or controlled activity relating to a vulnerable adult.⁷⁴ “Relevant information” relating to vulnerable adults includes information which would reveal whether the individual concerned is subject to monitoring in relation to regulated activity relating to vulnerable adults. Also, relevant information would include information which would show whether this individual is undergoing assessment.⁷⁵

(2) Northern Ireland

5.36 In Northern Ireland, when a person applied for employment that involved unsupervised access to children or vulnerable adults, then that person would be vetted in accordance with the so-called Pre-Employment Consultancy Service (PECS), provided that the prospective employer was registered with the Department of Health, Social Services and Public Safety (DHSSPS). The PECS system was established, on an administrative basis, following an inquiry into abuse at children’s homes. The PECS system provided a means for employers to access information held by the PSNI, the DHSSPS and the Department of Education, in order to enable them to determine the suitability of potential employees for roles that involved substantial access to children or vulnerable adults. Thus employers could avail of employment-related vetting in relation to the health and education sectors respectively. PECS was available to any statutory, voluntary, community or private sector organisation working with children and/or vulnerable adults.

5.37 The *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003* implemented the PECS system on a statutory basis in 2005. The 2003 Order enhanced arrangements for the safeguarding of vulnerable groups by establishing barred lists: (i) the Disqualification from Working with Children List (DWC List) and (ii) the Disqualification from Working with Vulnerable Adults List (DWVA List).⁷⁶ Under the 2003 Order a person who provided care for a vulnerable adult had a duty to refer a care worker to the DHSSPS if he or she dismissed the worker on grounds of misconduct or would have if the worker had not resigned or retired. Where the DHSSPS received such information, the individual would be provisionally placed on the list, while the DHSSPS

⁷³ Section 30(2)(b) of the *Safeguarding Vulnerable Groups Act 2006*.

⁷⁴ As per Schedule 7 of the *Safeguarding Vulnerable Groups Act 2006*.

⁷⁵ Section 31(3)(b) of the *Safeguarding Vulnerable Groups Act 2006*.

⁷⁶ Article 35 of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

considered all the information at hand. The DHSSPS had a responsibility to invite the individual concerned to make any observations on any information that it had. It was then the responsibility of the DHSSPS to determine whether or not to include the individual on a barred list, if the DHSSPS was of the opinion that the provider reasonably considered that the worker was guilty of misconduct and that the worker was unsuitable to work with vulnerable adults.⁷⁷

5.38 Where an individual was included in a barred list, other than provisionally, he or she had the right to appeal the decision to a Social Care Tribunal.⁷⁸ Where an individual was placed on the list provisionally for a period of more than 9 months, then he or she could apply to have his or her inclusion in the list determined by a Social Care Tribunal instead of by the DHSSPS. The Social Care Tribunal had the authority to allow the appeal, and then direct the removal of the individual from the list. The 2003 Order further provided that where an individual had been included on the list for a period of at least 10 years, then he or she could apply to a Social Care Tribunal to be removed from the list.⁷⁹ An application for removal would only be granted where the Social Care Tribunal was satisfied that the individual's circumstances had changed and that the change was such that leave should be granted.⁸⁰ The Order further provided for the restoration to the list of an individual who acts in such a way as to give reasonable cause to believe that vulnerable adults or children could be at risk of harm.⁸¹

5.39 Where a person was included in a barred list under the 2003 Order, he or she could not knowingly apply for, offer to do, accept or do any work in a care position, as to do so would constitute an offence.⁸² Any provider that sought to employ an individual, had to ascertain whether the individual concerned was included on the list, and if so, then that provider was precluded

⁷⁷ Article 36 of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁷⁸ Article 42 of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁷⁹ Article 43 of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁸⁰ Article 44(4) and (5) of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁸¹ Article 45 of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁸² Article 46(5) of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

from employing the individual.⁸³ Under the 2003 Order any person who wished to ascertain whether a relevant individual was included on a barred list simply had to apply to the DHSSPS and pay a set fee.⁸⁴

5.40 The 2003 Order was repealed by the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007*. The 2007 Order seeks to align Northern Ireland with the *Safeguarding Vulnerable Groups Act 2006*. The 2007 Order refers to the establishment of the IBB,⁸⁵ soon to be the ISA under section 1 of the *Safeguarding Vulnerable Groups Act 2006*. As under the 2006 Act, the 2007 Order imposes on providers of a regulated activity a duty to refer any individual to whom the provider withdraws permission to engage in the activity, if he or she has engaged in relevant conduct or he or she satisfies the harm test.⁸⁶

5.41 Once a reference of information is made to the ISA, the ISA must provisionally include that individual in the barred list and must using all the information available, then make a decision as to whether the individual should be confirmed on the list.⁸⁷ Any individual who is provisionally included on a barred list, awaiting a decision of the ISA, is entitled to make representations to the ISA as to why he or she should be removed from the list.⁸⁸ If the ISA confirms an individual's inclusion on a barred list, that individual can appeal the decision to a Social Care Tribunal⁸⁹ in accordance with section 4 of the *Safeguarding Vulnerable Groups Act 2006*. The 2007 Order also makes provision allowing a person included on a barred list to apply to the ISA for a review of his or her inclusion, with a view to his or her removal from the list. The 2007 Order contains the same criteria in this regard as those in the *Safeguarding Vulnerable Groups Act 2006*.

5.42 The 2007 Order also makes similar provision in relation to the commission of offences as those in the *Safeguarding Vulnerable Groups Act*

⁸³ Article 46(1) of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁸⁴ Article 47 of the *Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003*.

⁸⁵ Article 5 of the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007*.

⁸⁶ See Article 37 of the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007*. "Relevant conduct" is conduct which endangers a vulnerable adult or conduct of a sexual nature involving a vulnerable adult.

⁸⁷ Paragraph 8(3) of Schedule 1 of the 2007 Order.

⁸⁸ Paragraph 16(1) of Schedule 1 of the 2007 Order.

⁸⁹ Article 8 of the 2007 Order.

2006. Under the 2007 Order, where a person is placed on a barred list, and he or she seeks to engage, offers to engage or engages in regulated activity from which he or she is barred, then that person will be guilty of an offence.⁹⁰ A person will be guilty of an offence under the 2007 Order, if he permits an individual to engage in a regulated activity from which that individual is barred, and he or she knows that the individual is barred from the activity and the individual engages in that activity.⁹¹

5.43 The 2007 Order confers on the Secretary of State for Health, a responsibility, similar to that imposed by the *Safeguarding Vulnerable Groups Act 2006* provides. Under the 2007 Order, the Secretary of State must provide a person with vetting information where that person makes an application for such information in respect of another person whom he or she is considering employing in a regulated or controlled activity relating to a vulnerable adult.⁹²

(3) Scotland

5.44 In Scotland, a scheme, separate from the Independent Safeguarding Authority (ISA), is being established under the *Protection of Vulnerable Groups (Scotland) Act 2007*. The Scottish scheme will be aligned to the ISA and will co-operate with it. Under the Scottish legislation, anyone included on a barred list in Scotland will automatically be barred from working with either children or vulnerable adults in Scotland, England and Wales, and Northern Ireland. There are some differences between the 2006 Act and the Scottish 2007 Act. Under the 2007 Act, the term “protected adult” is used instead of “vulnerable adult”. A protected adult includes an individual aged over 16, who is provided with a prescribed service.⁹³ However, unlike the *Safeguarding Vulnerable Groups Act 2006* and the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007* the 2007 Act does not specifically refer to the provision of domiciliary care as a regulated activity. Regulated work with adults is defined as including work in a position whose normal duties include caring for protected adults and being in sole charge of protected adults.⁹⁴

5.45 The 2007 Act contains many provisions similar to those made under SVG legislation. One of the major differences between the 2007 Act and the SVG legislation is that the Scottish Ministers are responsible for maintaining the

⁹⁰ Article 11(1) of the 2007 Order.

⁹¹ Article 13(1) of the 2007 Order.

⁹² Section 32(1) of the *Safeguarding Vulnerable Groups (Northern Ireland) Order 2007*.

⁹³ Section 94 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

⁹⁴ Part 1 of Schedule 3 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

lists of barred individuals, as opposed to an independent body as in England and Wales, and Northern Ireland. Similar to the SVG legislation, the 2007 Act requires that where an organisation dismisses an individual on grounds that the individual harmed a protected adult, or placed a protected adult in harm, then the organisation must refer any prescribed information to the Minister.⁹⁵ If such an organisation fails to fulfil their duty as described, it will be guilty of an offence.⁹⁶ Where the Ministers are satisfied that the information indicates that it may be appropriate for the individual to be included in the adults' list, then they must consider listing the individual.⁹⁷ Where the Ministers receive information which indicates that the individual should be included in the adult's list, either from vetting information, or information received when considering whether to list the individual under the children's list, and the individual does regulated work with adults, then the Ministers must list the individual in the adult's list.⁹⁸ The Ministers must consider all of the information in order to determine whether the individual is suitable to work with adults.⁹⁹ Before making such a decision, the Ministers must give the individual an opportunity to make representations as to why he or she should not be listed. The Ministers must then take these representations into consideration when deciding whether to list the individual.¹⁰⁰

5.46 Under the 2007 Act, where an individual is listed under section 16, he or she may appeal to the sheriff against the decision.¹⁰¹ The sheriff can then either confirm the individual's listing or he or she can direct the Ministers to remove the individual from the adult's list.¹⁰² Either the individual or the Ministers can appeal the decision of the sheriff to the sheriff principal, the decision of whom is final.¹⁰³ Similar to the SVG legislation, a listed individual can apply to be removed from the adult's list after a prescribed length of time, under the 2007 Act, as per section 25(3). Where the Ministers are satisfied that the applicant is no longer unsuitable to work with protected adults, the Ministers can

⁹⁵ Section 3 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

⁹⁶ Section 9 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

⁹⁷ Section 10(3) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

⁹⁸ Section 12(2) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

⁹⁹ Section 16 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰⁰ Section 17(1)(a) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰¹ Section 22(1) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰² Section 22(3)(b) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰³ Section 23 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

remove the individual from the adult's list.¹⁰⁴ An individual may also appeal to the sheriff against the Ministers decision not to remove him or her from the list.¹⁰⁵

5.47 Where an individual is on a list, it is an offence for him or her to do, or to seek or agree to do, any regulated work from which he or she is barred.¹⁰⁶ It is also an offence for an organisation to offer regulated work to an individual that is barred from that type of work.¹⁰⁷ A further example of co-operation between the jurisdictions is evident in the 2007 Act, whereby the Scottish Ministers can refer information to the ISA where they consider that the Authority is the more appropriate forum for the individual's case to be determined.¹⁰⁸

5.48 Where an individual is already included in the adults' barred list as maintained under section 2 of the *Safeguarding Vulnerable Groups Act 2006*, the Scottish Ministers do not need to list the individual in the adults' list as provided for under Scottish legislation.¹⁰⁹ Under the 2007 Act where the ISA decides not to include an individual in the adults' barred list, and the Scottish Ministers that the ISA considered all the relevant information, then the Ministers do not need to list the individual in the adults' list.¹¹⁰

5.49 There is significant provision under the *Protection of Vulnerable Groups (Scotland) Act 2007* for the vetting of potential staff and the disclosure of information.¹¹¹ The Scottish Ministers are required to administer a scheme under which information about individuals who do regulated work with vulnerable adults is collated and disclosed in accordance with the 2007 Act.¹¹² Individuals who work with, or who wish to work with vulnerable adults, may apply to the Ministers to become a member of the scheme, provided he or she is not barred from doing the work.¹¹³ The Ministers must create a new record for each scheme member, and ascertain any vetting information that there may be

¹⁰⁴ Section 26(2)(a) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰⁵ Section 27 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰⁶ Section 34 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰⁷ Section 35 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰⁸ Section 40(2)(a) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹⁰⁹ Section 40(1) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹¹⁰ Section 40(3) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹¹¹ Part 2 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹¹² Section 44 of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹¹³ Section 45(1)(b) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

about the individual. Ministers must make arrangements for the purpose of discovering whether any new vetting information arises in relation to scheme members while those members participate in the scheme.¹¹⁴ Where any new information comes to light, the Ministers must update the scheme record accordingly. The 2007 Act also provides for the disclosure of scheme records on condition that:

- (i) the scheme member requests the disclosure,
- (ii) the scheme member participates in the scheme in relation to that type of regulated work,
- (iii) the person to whom the disclosure is to be made is requesting the information for the purpose of enabling him or her to consider the scheme member's suitability to do the type of regulated work, and
- (iv) the person to whom the disclosure is to be made is registered under the *Police Act 1997*.

5.50 Where these conditions are all satisfied the Ministers must disclose the scheme member's record.¹¹⁵

(4) Australia

5.51 Under the *Aged Care Act 1997*, approved providers of residential care are required to report to the police and the Department of Health and Ageing, any incidents involving alleged or suspected reportable assaults¹¹⁶ within 24 hours of when the provider starts to suspect that there may be such an incident.¹¹⁷ Approved providers are required to take reasonable measures to ensure that members of staff who provide a service in connection with the approved provider's residential care service report any suspicions or allegations of reportable assaults to either the approved provider, the police or the Department.¹¹⁸ Where an employee makes such a disclosure, the approved provider has a responsibility to take reasonable measures to ensure that the identity of the employee is protected, and that such employees are not

¹¹⁴ Section 47(2) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹¹⁵ Section 54(1) of the *Protection of Vulnerable Groups (Scotland) Act 2007*.

¹¹⁶ A "reportable assault" is defined as unlawful sexual contact, the unreasonable use of force, and other offences, as per section 63-1AA(9) of the *Aged Care Act 1997*.

¹¹⁷ Section 63-1AA(1) of the *Aged Care Act 1997*.

¹¹⁸ Section 63-1AA(5) of the *Aged Care Act 1997*.

subjected to victimisation.¹¹⁹ There are specific exceptions to this general requirement to report incidents under section 63-1AA(1), for example where the alleged assault is perpetrated by another resident of the facility, who has an assessed cognitive or mental impairment. This obligation to report alleged or suspected reportable assaults, does not appear to extend to providers, or employees of domiciliary care agencies. Section 63-1AA of the *Aged Care Act 1997* applies to approved providers of residential care only.

5.52 Comprehensive guidelines were published in 2006, by the Australian Department of Health and Ageing to assist approved providers to meet their requirements under the *Aged Care Act 1997*, for criminal history record checks for relevant staff and volunteers working in Australian Government subsidised aged care services.¹²⁰ Under the new requirements, all Australian Government subsidised services; including residential aged care services, community aged care services and flexible care services, are required to ensure that all staff employed by them, and volunteers, undergo regular criminal history record checks, obtain a national police certificate that is not older than 3 years, and are assessed as being suitable to work in aged care.¹²¹ A police check is a check undertaken by State or Territory Police Services or the Australian Federal Police that discloses evidence of whether a person has any recorded convictions, or has been charged with, and found guilty of an offence, but was discharged without conviction, or is the subject of any criminal charge still pending before a Court. Where a person has been convicted of murder or sexual assault or convicted of, and sentenced to imprisonment for any other form of assault, he or she will be deemed to be unsuitable to work in the aged care sector, and consequently he or she must not be employed to provide care or ancillary duties in the aged care sector.¹²²

5.53 The guidelines emphasise that, though it is the responsibility of the approved provider to ensure that all relevant staff and volunteers have appropriate and valid police certificates, the arrangements for obtaining such certificates is an issue that must be negotiated between the aged care provider

¹¹⁹ Section 63-1AA(6)-(7) of the *Aged Care Act 1997*.

¹²⁰ *Police Certificate Guidelines for Aged Care Providers* (Department of Health and Ageing, Australian Government, 2006) available at www.health.gov.au.

¹²¹ *Police Certificate Guidelines for Aged Care Providers* (Department of Health and Ageing, Australian Government, 2006) available at www.health.gov.au at p3.

¹²² *Police Certificate Guidelines for Aged Care Providers* (Department of Health and Ageing, Australian Government, 2006) available at www.health.gov.au at p14.

and the individual concerned.¹²³ Such an individual may either obtain a police certificate and furnish it to the provider, or he or she may give his or her consent for the approved provider to request a police certificate from the relevant body. The approved provider is responsible for obtaining an individual's consent and recording it in an acceptable format that meets the provisions of the *Privacy Act 1988*. The *Aged Care Act 1997* sets out detailed requirements in terms of the approved providers responsibilities in relation to the protection of personal information.¹²⁴ The 1997 Act provides that personal information must not be used other than for the purpose connected with the provision of aged care, and this information must not be disclosed to another party except with the written consent of the individual.¹²⁵ The 1997 Act further provides that approved providers have a responsibility to take all reasonable measures to protect all personal information, to prevent against the loss or misuse of such information.¹²⁶

(5) Alberta

5.54 In Alberta the *Protection of Persons in Care Act 2000* was introduced to safeguard vulnerable people who were receiving care. The 2000 Act is scheduled to be replaced by the *Protection of Persons in Care Act 2009* but the 2009 Act has currently (July 2009) not yet come into force. The 2009 Act will apply to public institutions that provide care to vulnerable adults, and to social care facilities that are places of care for persons who are aged or infirm or who require special care.¹²⁷ It is unclear as to whether this includes domiciliary care agencies. The purpose of the 2009 Act is to prevent abuse of clients of these care services, by requiring the mandatory reporting of abuse, and to ensure that such complaints are independently reviewed.¹²⁸ Section 7(1) of the 2009 Act requires that every individual who has reasonable grounds to believe that there is or has been abuse of a client of a care service provider, must report the abuse to an authorised person, as soon as is reasonably practicable. Anyone who fails to comply with this duty, will be guilty of an offence.¹²⁹ The 2009 Act also confers on every service provider and individual employed by or engaged

¹²³ *Police Certificate Guidelines for Aged Care Providers* (Department of Health and Ageing, Australian Government, 2006) available at www.health.gov.au at p12.

¹²⁴ Section 62.1 of the *Aged Care Act 1997*.

¹²⁵ Section 62-1(b) of the *Aged Care Act 1997*.

¹²⁶ Section 62.1(c) of the *Aged Care Act 1997*.

¹²⁷ Section 1(h)(i) of the *Social Care Facilities Review Licensing Act* .

¹²⁸ Section 2 of the *Protection of Persons in Care Act 2009*.

¹²⁹ Section 7(5) of the *Protection of Persons in Care Act 2009*.

for services by a service provider, who provides care or support services to a client, a duty to take reasonable steps to protect the client from abuse while providing the care and to maintain a reasonable level of safety for the client.¹³⁰ The 2009 Act further protects those that report abuse, by prohibiting service providers and individuals employed by or engaged for services by a service provider, from taking adverse action against the individual for reporting the abuse.¹³¹ The 2009 Act offers some safeguards for service providers, by making it an offence for someone to report abuse that they know to be false or malicious, or where the individual does not have reasonable grounds to believe the information is true.¹³²

5.55 The distinction between the 2000 Act and the 2009 Act, lies in the introduction by the 2009 Act of complaint officers. Under the 2000 Act, where a complaint was made to the police service or the relevant Minister, an investigator would be appointed to conduct an investigation into the complaint.¹³³ This investigator would then compile a report of the findings, which would be sent to the relevant Minister, who could then refer the matter to the police service, or where the agency against which the complaint was made, is in receipt of funding from the Crown or a Crown agency, the Minister could review or alter that funding.¹³⁴ The Minister could also recommend that the agency involved in the complaint take disciplinary proceedings against an employee or a service provider.

5.56 Under the 2009 Act, the system for investigating complaints of abuse will change. The 2009 Act will introduce dedicated complaints officers, to whom complaints about the provision of care can be made.¹³⁵ The complaints officers will conduct preliminary investigations into complaints, before deciding whether the issue warrants further investigation by a dedicated investigator.¹³⁶ All interested parties must be notified of the complaints officer's decision. Once a matter has been referred to an investigator, he or she must fully investigate the complaint. Investigators have considerable investigative powers, including the authority to enter any relevant property and access any relevant documents, as well as being able to interview any person who might have relevant

¹³⁰ Section 10(1) of the *Protection of Persons in Care Act 2009*.

¹³¹ Section 18 of the *Protection of Persons in Care Act 2009*.

¹³² Section 24 of the *Protection of Persons in Care Act 2009*.

¹³³ Section 7 of the *Protection of Persons in Care Act 2000*.

¹³⁴ Section 8(3)(a) of the *Protection of Persons in Care Act 2000*.

¹³⁵ Section 7(1) of the *Protection of Persons in Care Act 2009*.

¹³⁶ Section 11(5) of the *Protection of Persons in Care Act 2009*.

information.¹³⁷ A final report is then furnished to the Director. The Director is appointed by the Minister and has all of the functions of a complaints officer and an investigator.¹³⁸ The Director makes a decision based on the investigator's final report, as to what he or she thinks is appropriate to prevent the abuse of clients. A copy of the decision must be supplied to all interested parties, and the client and the individual involved must be notified of the right to appeal the decision to an appeal panel.¹³⁹ An appeal must be made within 15 days of the party's receipt of the notification. On appeal, the appeal panel may confirm, reverse or vary the Director's decision, and the appeal panel's decision is final.¹⁴⁰

(6) British Columbia

5.57 Part 3 of the *Adult Guardianship Act 1996* provides for the support and assistance of abused and neglected adults. The 1996 Act introduced the concept of voluntary reporting of suspected abuse of vulnerable adults to British Columbia. Part 3 of the 1996 Act applies whether an adult is abused or neglected in a public place, in the adult's own home, in a relative's home or some other care facility.¹⁴¹ This provision thus includes domiciliary care agencies, as well as informal carers. Under section 46 of the 1996 Act, anyone who has information which indicates that an adult is being abused or neglected, and is unable to prevent the abuse, may report the abuse to a designated agency. The 1996 Act also offers whistle-blowers protection to safeguard those who make such reports about alleged abuse from legal action for damages.¹⁴² Employees who make such voluntary reports of abuse or neglect are also protected under the 1996 Act.¹⁴³ Employers are not allowed to refuse to employ or to refuse to continue employing a person who has made a disclosure under section 46. Employers are also precluded from threatening to dismiss, discriminate against and or intimidate such employees.

5.58 Once a report of abuse is made to a designated agency, the agency must determine whether the adult in question is being abused or neglected, and

¹³⁷ See in general section 12 of the *Protection of Persons in Care Act 2009*.

¹³⁸ Section 4 of the *Protection of Persons in Care Act 2009*.

¹³⁹ Section 15(1)(d) of the *Protection of Persons in Care Act 2009*.

¹⁴⁰ Section 17(6)-(7) of the *Protection of Persons in Care Act 2009*.

¹⁴¹ Section 45 of the *Adult Guardianship Act 1996*.

¹⁴² Section 46(3) of the *Adult Guardianship Act 1996*.

¹⁴³ Section 46(4) of the *Adult Guardianship Act 1996*.

whether he or she needs support and assistance.¹⁴⁴ If the designated agency determines that the adult does not need support or assistance, because there is no evidence of abuse or neglect, then no further action is taken.¹⁴⁵ However, where the designated agency determines that the adult in question needs support or assistance, then the agency can refer the adult to available health and social services, inform the Public Guardian and Trustee and/or investigate the report to determine if the adult is abused or neglected.¹⁴⁶ The designated agency has the authority to interview relevant persons in order to obtain relevant information about the report of abuse. The designated agency also has the power to enter premises in order to interview someone, as part of the investigation.¹⁴⁷ After conducting an investigation, the designated agency may determine that no further action is necessary, may refer the matter to the Public Guardian and Trustee, may apply to the court for any interim orders necessary to protect the individual concerned, or may prepare a support and assistance plan to meet the needs of the individual.¹⁴⁸ Where such a plan is prepared, the designated agency may apply to the court for an order authorising the provision of services.¹⁴⁹ On hearing the application, the Court must consider whether the adult is being abused or neglected, is unable to seek support and assistance, and needs the services proposed in the plan.¹⁵⁰ Where the Court finds that a person is being abused or neglected, it may order a person found to be abusing the adult to stop residing at or to stay away from the premises where the abused adult lives, or not to visit or harass the adult. The Court may order that such a person must pay for, or contribute towards the adult's maintenance or services to be provided for the adult.¹⁵¹ The 1996 Act protects those who act on behalf of designated agencies, from personal liability for anything done in good faith in the exercise or performance of their powers, duties and functions as prescribed by the Act.¹⁵² Neither the designated agency nor the government are

¹⁴⁴ Section 47(1) of the *Adult Guardianship Act 1996*.

¹⁴⁵ Section 47(3) of the *Adult Guardianship Act 1996*.

¹⁴⁶ Section 47(3) of the *Adult Guardianship Act 1996*.

¹⁴⁷ Section 48 of the *Adult Guardianship Act 1996*.

¹⁴⁸ Section 51(1) of the *Adult Guardianship Act 1996*.

¹⁴⁹ Section 54 of the *Adult Guardianship Act 1996*.

¹⁵⁰ Section 56 of the *Adult Guardianship Act 1996*.

¹⁵¹ Section 56(3)(c) of the *Adult Guardianship Act 1996*.

¹⁵² Section 60.1(1) of the *Adult Guardianship Act 1996*.

absolved from vicarious liability for an act or omission for which it would be vicariously liable if this section were not in force.¹⁵³

5.59 *The Commission invites submissions on the issues of mandatory and voluntary reporting of abuse of vulnerable adults, by all persons, including employees of domiciliary care providers.*

E Screening of domiciliary care professionals

5.60 Domiciliary care workers play an important role in the lives of the people that they care for. These carers have a responsibility towards the person they care for to minimise both the likelihood of abusive situations occurring and to contribute to the monitoring of those that may be considered to be at risk.¹⁵⁴ There is a need to introduce measures that will protect vulnerable adults who receive domiciliary care from abuse. Part of these protection measures must include proper procedures for screening domiciliary care professionals. Such a system would have to balance the need to protect vulnerable adults and the need to protect the rights of the individual concerned to privacy and due process. In this Part, the Commission examines different options that could be implemented to screen domiciliary care workers. The role of the GCVU as it extends to the screening of domiciliary care workers is also discussed. The option of certifying individuals, and setting out requirements for such certification is also considered.

(1) Disclosure of information

5.61 Given the exposure vulnerable people have to possible exploitation and abuse, the Commission considers that screening measures should be in place for those who provide care to the vulnerable person. Currently, any organisation that recruits and selects persons who would have substantial unsupervised access to children and/or vulnerable adults can make a request for information about prospective employees and volunteers from the GCVU. Such persons include employees of the HSE and agencies funded by the HSE that would have access to vulnerable persons, as well as staff working in care homes for older people.¹⁵⁵ There is no express provision that requires domiciliary care workers to undergo a vetting procedure before commencing

¹⁵³ Section 60.1(2) of the *Adult Guardianship Act 1996*.

¹⁵⁴ Expert Advisory Group and Governance Group *National Quality Home Care Support Guidelines* (Health Service Executive, 2008) at 14.

¹⁵⁵ The Commission examined this issue in its Report on Spent Convictions (LRC 84-2007) Chapter 4, p 100.

employment. Domiciliary care agencies can voluntarily approach the GCVU to request that a check on potential employees is carried out, but this is not as yet a mandatory obligation.

5.62 The 2004 *Report of the Working Group on Garda Vetting* recognised that this type of screening is only one element of safe recruitment practices, and should not be solely relied on by employers. Voluntary disclosure by potential employees is another element of safe recruitment practices. Under HIQA's 2007 *Standards for Residential Care Settings for Older People*, all persons employed in a residential care setting will be subjected to a satisfactory Garda vetting procedure, which will also include screening from other jurisdictions.¹⁵⁶ The standards also provide that in addition to a satisfactory GCVU vetting, all new staff in residential care settings must supply two references, including a reference from their last employer. These prospective employees must also confirm their registration or validate their status, as well as verify their qualifications, before their employment will be confirmed.¹⁵⁷ Employers also have a responsibility to explore any gaps that appear in the individual's employment history.

¹⁵⁶ Health Information and Quality Authority *Standards for Residential Care Settings for Older People*, available at www.hiqa.ie, Standard 22.2.

¹⁵⁷ *Ibid.*

(2) Registration and certification

5.63 In Chapter 1, the Commission provisionally recommended that the Health Information and Quality Authority (HIQA) and the Office of the Chief Inspector of Social Services (SSI) should be empowered to regulate and monitor domiciliary care providers. These measures, if introduced, would confer on HIQA the authority to set standards which domiciliary care providers would have to meet whilst providing their services. These standards could set out certain core competencies that domiciliary care providers would have to meet, with regard to staffing the service. By extending the scope of SSI, this will ensure that all domiciliary care providers must apply for registration. In accordance with the registration process already provided for under the *Health Act 2007* for residential care providers, the registration process for domiciliary care providers would be based on any standards that HIQA would set out for domiciliary care providers. Before granting all applications to care providers, SSI must be satisfied that the applicant is compliant with any relevant HIQA standards.¹⁵⁸ This provision would apply to domiciliary care providers. Where a care provider successfully registers with SSI, a certificate of registration is issued to the applicant,¹⁵⁹ and if there are any conditions which SSI decides to attach to the registration, then the certificate clearly sets these out.

5.64 The *Health Act 2007* already provides a statutory framework by which domiciliary care providers could easily be regulated and monitored. Where an individual works as an independent professional domiciliary carer, the issue then arises as to how he or she can be regulated and monitored. As already discussed in Chapter 1, the *Health and Social Care Professionals Act 2005* is not a suitable framework for the registration of domiciliary care professionals.¹⁶⁰ There is, in the Commission's view, a need to establish a register of all independent professional carers. This would ensure that such carers are properly registered with a particular body that would regulate and inspect each individual carer to ensure that they are complying with any standards and regulations. Under the framework set out by the *Health Act 2007*, HIQA is in a prime position to initiate the registration and monitoring of individual professional domiciliary carers. Under this system, individual professional domiciliary carers would be required to register with SSI, which, if it approves the application, would issue each carer with a certificate of registration. SSI would then be responsible for the monitoring of registered

¹⁵⁸ Section 50(1)(b) of the *Health Act 2007*.

¹⁵⁹ Section 50(3) of the *Health Act 2007*.

¹⁶⁰ As per section 4 of the *Health and Social Care Professionals Act 2005*.

professional domiciliary carers. These measures would go some way toward ensuring that professional domiciliary carers would comply with any standards published by HIQA. As provided for in the National Quality Standards for Residential Care Settings for Older People, any standards for professional domiciliary carers could include a requirement to provide references, details of qualifications and Garda vetting to anyone who wishes to employ such a carer. If a domiciliary care worker was then found guilty of an offence as prescribed by section 51(2) of the *Health Act 2007*, then his or her registration could be cancelled, and he or she could be decertified.

5.65 *The Commission invites submissions on the establishment of a specific register of professional domiciliary carers, which would be operated by HIQA, and would set out specific requirements in relation to the registration and monitoring of professional domiciliary carers.*

CHAPTER 6 SUMMARY OF PROVISIONAL RECOMMENDATIONS

6.01 The Commission’s provisional recommendations in this Consultation Paper may be summarised as follows.

6.02 The Commission provisionally recommends that section 8(1)(b) of the Health Act 2007 be amended to extend the authority of the Health Information and Quality Authority to include the regulating and monitoring of professional domiciliary care providers.[Paragraph 1.42]

6.03 The Commission provisionally recommends the amendment of the definition of a “designated centre” in section 2(1) of the Health Act 2007 to include domiciliary care providers. This would extend the power of the Office of the Chief Inspector of Social Services under section 41 of the Health Act 2007 to register and monitor professional domiciliary care providers. [Paragraph 1.46]

6.04 The Commission provisionally recommends extending the Ministerial regulation-making power conferred on the Minister for Health and Children by section 101 of the Health Act 2007 to include the authority to make Regulations in respect of professional domiciliary care providers.[Paragraph 1.48]

6.05 The Commission provisionally recommends that HIQA publish standards which should be specifically tailored for the domiciliary care setting, building on existing HIQA standards for the residential care setting. The Commission also provisionally recommends that the proposed standards should ensure that domiciliary care is provided in a manner that promotes the well-being and independence of the service user in their own home. [Paragraph 2.95]

6.06 The Commission provisionally recommends that the terms and conditions of the provision of care be agreed and recorded in a care contract, in order to offer the maximum protection to the service user. [Paragraph 3.20]

6.07 The Commission provisionally recommends that the care contract should contain specific policies in relation to the entering and leaving of the service recipient’s home by the carer. [Paragraph 3.25]

6.08 The Commission provisionally recommends that the care contract should contain clear policies and procedures in relation to the handling by the carer of money and personal property of the service recipient. The Commission

also provisionally recommends that there should be clear policies in place regarding the refusal of gifts from the service recipient. [Paragraph 3.32]

6.09 The Commission provisionally recommends that the care contract should set out specific policies and procedures in relation to the management of a service recipient's medication. [Paragraph 3.39]

6.10 The Commission provisionally recommends that an individual who wishes to enter into an arrangement for the provision of domiciliary care services should have the option to contract with an intermediary, whether a State body or a private sector body, who would arrange for the provision of care and who would assume the responsibilities of an employer towards the domiciliary carer. [Paragraph 4.09]

6.11 The Commission invites submissions as to whether a subvention arrangement, comparable to that for nursing homes in the Nursing Homes Support Scheme Act 2009, should be extended to community-based provision of domiciliary care. [Paragraph 4.19]

6.12 The Commission provisionally recommends that an individual who wishes to pay for the provision of domiciliary care services should have the option to contract directly with the HSE for such services. [Paragraph 4.22]

6.13 The Commission provisionally recommends that section 469 of the Taxes Consolidation Act 1997 should be extended to provide tax relief for fees incurred by an individual in meeting the cost of domiciliary care. [Paragraph 4.27]

6.14 The Commission provisionally recommends that there should be public education of the fact that a service user could be regarded as an employer of a professional carer if the service user does not contract directly through an intermediary, whether private sector or the State, for the provision of professional domiciliary care. [Paragraph 4.32]

6.15 The Commission provisionally recommends that any contract for the provision of domiciliary care services should include specific provisions that set out the financial arrangement between the contracting parties for the agreed services. [Paragraph 4.39]

6.16 The Commission provisionally recommends that any contract for domiciliary care provision should make specific reference to the responsibilities that arise under employment law, including any specific issues arising under safety and health legislation. [Paragraph 4.52]

6.17 The Commission invites submissions on whether it is appropriate that, in connection with an individual whose capacity to enter into a contract is in doubt or may be absent, a "general authority" to act on the person's behalf could include entering into a contract for the provision of domiciliary care or

whether this should be a matter only for a personal guardian or an attorney appointed under an enduring power of attorney. [Paragraph 4.59]

6.18 The Commission endorses the proposal in head 27 of the Government's Scheme of Mental Capacity Bill 2008 to create an offence of ill treatment or wilful neglect as involving an important protective element in the context of domiciliary care. [Paragraph 5.15]

6.19 The Commission invites submissions as to whether the form of protection for people who report concerns about incidents of possible abuse contained in the Protection of Persons Reporting Child Abuse Act 1998 should be extended to apply in the context of professional domiciliary care. [Paragraph 5.20]

6.20 The Commission provisionally recommends that Part 9A of the Health Act 2004, which deals with disclosure of abuse, be amended, to ensure that employees of domiciliary care providers will be covered by the protected disclosure safeguards. [Paragraph 5.28]

6.21 The Commission invites submissions on the issues of mandatory and voluntary reporting of abuse of vulnerable adults, by all persons, including employees of domiciliary care providers. [Paragraph 5.59]

6.22 The Commission invites submissions on the establishment of a specific register of professional domiciliary carers, which would be operated by HIQA, and would set out specific requirements in relation to the registration and monitoring of professional domiciliary carers. [Paragraph 5.65]



The Law Reform Commission is an independent statutory body established by the *Law Reform Commission Act 1975*. The Commission's principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify and modernise the law.

This role is carried out primarily under a Programme of Law Reform. The Commission's *Third Programme of Law Reform 2008-2014* was prepared and approved under the 1975 Act following broad consultation and discussion. The Commission also works on specific matters referred to it by the Attorney General under the 1975 Act. Since 2006, the Commission's role also includes two other areas of activity, Statute Law Restatement and the Legislation Directory. Statute Law Restatement involves incorporating all amendments to an Act into a single text, making legislation more accessible. The Legislation Directory (previously called the Chronological Tables of the Statutes) is a searchable guide to legislative changes.

€15

ADDRESS
35-39 Shelbourne Road Dublin 4 Ireland

TELEPHONE
+353 1 6377600

FAX
+353 1 6377601

EMAIL
info@lawreform.ie

WEBSITE
www.lawreform.ie

The Law Reform Commission is a statutory body established by the Law Reform Commission Act 1975