



Health and Social  
Services Councils  
of Northern Ireland



The Regulation and  
Quality Improvement  
Authority

# Are you Being Heard?

**A Review Of Access To  
Advocacy Services For Older People  
in Care Homes in Northern Ireland**

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## FOREWORD

The four Health and Social Services Councils and the Regulation and Quality Improvement Authority, as a result of engagement with users of health and social care, recognise the challenges of delivering effective advocacy. Advocacy services have the potential to enhance and improve health and social care outcomes. However, they are not widely available at present and are often poorly understood.

The outcome of this care home audit report demonstrates the importance of advocacy to those within residential and nursing homes in Northern Ireland. Advocacy is a much valued support mechanism for relatives who may undertake this role. This report indicates the need for shared common standards for advocacy arrangements.

The learning from this audit represents an opportunity for commissioners and providers to review advocacy provision within the care home sector and put in place an effective advocacy service for this vulnerable group.



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## EXECUTIVE SUMMARY

Advocacy is a process of influencing people to create change. It is a positive process of communication about people's needs and providing solutions to meet these needs. It is particularly relevant for all those who are vulnerable in some way, for example older infirm people.

This audit of access to advocacy services for older people in care homes has been undertaken by the four Health and Social Services Councils and the Regulation Quality Improvement Authority. Its aims were to:

- Report on access to advocacy services for older people in publicly funded places in care homes.
- Assess the current extent of available advocacy services.
- Identify strengths and weaknesses in current arrangements.
- Highlight best practice.
- Support improvement by identifying a way forward.

The processes used to conduct the audit were as follows:

- Agreed definition of advocacy.
- Agreed the methods used to gather data.
- Mapped location/type of homes.
- General desk research and information gathering.
- Questionnaires sent to all registered care homes.
- Held a residents' focus group.
- Held a relatives' focus group.
- Held a reference group for stakeholders.
- Hosted a seminar of all interested parties to comment on initial findings.
- Sought an expert review of outputs.
- Produced a final report including recommendations for policy and practice.

### Background to the Review

- It is widely accepted that there is a need to develop joined up working across the new post-Review of Public Administration Health and Social Care organisations. The four HSSCs were conscious that their responsibilities in relation to advocacy following this audit also required further clarification and it was important to obtain views of other stakeholders in this regard.

- A more strategic approach to advocacy services in care homes is needed if residents are to have access to appropriate types of advocacy to meet their needs in different situations. This should recognise the relative merits of advocacy provided by care home staff and other professionals as well as other models such as independent advocacy.

## **Care Homes - Results of Questionnaires**

- A questionnaire was devised by the Steering Group, distributed to care homes and returned via mail and analysed descriptively. A follow-up seminar was arranged.
- The 39% return rate for the postal questionnaire and the good attendance at the seminar showed a positive interest and engagement from the care home sector.
- Over half of care homes agreed on a common definition of advocacy as “acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon.” Currently advocacy may be provided by a range of independent providers. There was no evidence that providers shared common standards or whether input was provided on a one-off/occasional basis or on a longer term, sustainable way.
- Most of the care homes that provided advocacy arrangements did so in-house and consider advocacy as part of their core work.
- The main ways of informing people about advocacy was through printed residents’ guides or by word of mouth before or at the time of admission. In some cases information was on display in the home.
- Where homes did not believe that they offered advocacy services, there was a high level of interest in putting arrangements in place.
- Care home managers felt that residents (and their relatives) would know how to go about accessing advocacy.
- Where staff training in advocacy is provided, it is delivered primarily through induction training.

## **Residents' Focus Groups**

- There was a lack of awareness of advocacy and information for residents.
- Not all residents felt the need for an advocacy service believing that their support needs were already being met.
- Good staffing levels appeared to improve the 'listening culture' of the care home.
- The role of relatives and staff was valued as a source of advocacy indicating the primary need to focus advocacy work on residents without close family.
- In care homes where there were independent advocates, this service was valued by the residents.
- The needs of residents with dementia and learning disability require particular attention due to their special needs and communication challenges associated with their conditions.
- The reluctance of residents to complain or make requests eg for privacy in making telephone calls or commenting on slow responses to requests for attention to basic needs, was noted in several groups.
- Accessibility to medical and related services such as GP/podiatry, is likely to be an issue for advocates who would need a good knowledge of how such services work and how residents can avail of them.
- Group work may not be an effective way of relating to all residents.
- Advice on the financial implications prior to admission to a care home was an important issue.

## **Relatives' Focus Groups**

- There was some difference of opinion between relatives and care home providers regarding who should provide advocacy services.
- Relatives favoured more independence in advocacy services.

- Relatives showed some reluctance to put themselves forward as the main advocate.
- While care homes stated that advocacy information was available and displayed, relatives did not recall seeing this.
- Relatives supported an accessible, impartial advocacy service staffed by knowledgeable people with power to act
- It was felt that care homes should be approached in the first instance where there was a concern but that advocacy services might be advised where care home staff took no action or in the case of 'serious' issues.
- Some other useful suggestions were put forward which relatives would find helpful e.g. a telephone helpline, relatives' groups, advocacy clinics and an information pack.

## **Stakeholders' Reference Group**

- Stakeholders viewed their own advocacy arrangements in a positive light.
- They felt advocacy is most effective in supporting people to speak out and put forward their views.
- Work is required in understanding and promoting the advocacy role.
- Barriers to advocacy include lack of awareness, funding and resistance from providers, and reluctance to complain.
- The concept of an independent, accessible, confidential service with trained staff operating within a strict code of practice was supported.
- Advocacy services should be well publicised and free to the user.
- Effective advocacy would be delivered according to an agreed guideline in partnership between users, carers and service providers.

## RECOMMENDATIONS

1. The DHSSPS should supplement the published Nursing and Residential Care Home Standards by adopting the following definition of advocacy as set out in this Report.

“Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon.” (*Scottish Independent Advocacy Alliance*)

2. The DHSSPS in their review of funding should explore the feasibility of the HSC delivering sustainable, independent, centrally funded advocacy services to people in care homes.
3. HSC commissioners and providers should continue to promote and facilitate an advocacy service model that is equitable, flexible, relevant and responsive to the needs of service users, building on existing regional expertise and best practice.
4. Service commissioners who contract for care services should ensure that the service specification includes a quality standard for advocacy, which should be measured and monitored.
5. HSC bodies should acknowledge and support the existing advocacy role of care home staff and other professionals.
6. RQIA, through its inspection process, will review compliance and make recommendations to providers to ensure access to advocacy is put in place.
7. Advocacy services should be free to the user and actively promoted and publicised by all providers.

## GLOSSARY

**Advocacy** - “Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon.” (*Scottish Independent Advocacy Alliance*)

**Bryson House** (now known as Bryson Charitable Group) – a registered charity helping to change people’s lives by identifying and developing sustainable responses to existing and emerging social need. Working inclusively in partnership with other services, organisations and communities, the Group provides a range of services to the most vulnerable people in Northern Ireland.

**Care Homes** – establishments (also known as nursing or residential homes) where people can live who are no longer able to live at home.

**Department of Health, Social Services and Public Safety (DHSSPS)** – a government department set up to improve the health and well-being of the people of Northern Ireland by ensuring the provision of appropriate health and social care services, both in clinical settings such as hospitals and doctor surgeries and in the community through nursing, social work and other professional services. It also leads a major programme of cross-government action to improve the health and well-being of the population and reduce health inequalities.

**Health and Social Care (HSC)** – this is an integrated service in Northern Ireland. The four Health and Social Services Boards are agents of the Department of Health, Social Services and Public Safety in planning, commissioning and purchasing services for the residents in their areas.

**Health and Social Services Councils (HSSCs)** – organisations responsible for representing the views and opinions of the public in regard to health and social care issues. They monitor health and social care and are independent from those who plan, manage and provide such services.

**National Institute for Clinical Excellence (NICE)** - is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

**Office of Fair Trading (OFT)** – the United Kingdom’s competition and consumer authority. Its mission is to make markets work well for consumers aiming for competitive, efficient and innovative markets where standards of consumer care

are high and where businesses comply with competition and consumer law.

**Patient Client Council (PCC)** - proposed body to replace the HSSCs, which would give patient, client and carer representatives a powerful regional voice but also ensure a strong, local focus and provide locally elected representatives with an active role.

**Regulation and Quality Improvement Authority (RQIA)** - the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

**Review of Public Administration (RPA)** – a comprehensive examination of the arrangements for the administration and delivery of public services in Northern Ireland. It covered over 150 bodies, including the District and Borough Councils, the Health and Social Services Boards, Councils, Trusts, and Agencies and the five Education and Library Boards. Implementation is currently being taken forward.

**Social Care Institute for Excellence (SCIE)** - was established by the Government in 2001 to improve social care services for adults and children in the UK. They achieve this by identifying good practice and helping to embed it in everyday social care provision.

**Super Complaint** – a complaint submitted by a designated consumer body that 'any feature, or combination of features, of a market in the United Kingdom for goods or services is or appears to be significantly harming the interests of consumers'.

**WHICH?** – a subscription-only magazine and website run by the Consumers' Association in the United Kingdom. It campaigns on various consumer issues and aims to promote informed consumer choice in the purchase of goods and services, by testing products, highlighting inferior products or services and raising awareness of consumer rights.

# 1 BACKGROUND TO THE REVIEW

## 1.1 Introduction

This review of access to advocacy services for older people in care homes was undertaken by the four Health and Social Services Councils in partnership with the Regulation Quality Improvement Authority. Its aims were to:

- Report on access to advocacy services for older people in publicly funded places in care homes.
- Assess the current extent of available advocacy services.
- Identify strengths and weaknesses in current arrangements.
- Highlight best practice locally.
- Support improvement by identifying a way forward.

## 1.2 Office of Fair Trading Market Study

The review came from a process begun in 2003 when WHICH? magazine made a Super Complaint to the Office of Fair Trading with regard to the experience of older people in care homes. In response to this super complaint, the Office of Fair Trading undertook a market study<sup>1</sup> which looked at "... how well the care home market is serving older people in the context of government policies on the care of older people". The market study highlighted a number of causes for concern. These areas of concern included information about moving into a home, authority obligations, price transparency, contracts and access to making complaints.

As part of the recommendations in relation to the making of complaints, the market study noted, *"Therefore, we recommend that the Department of Health and the devolved administrations should run pilot projects to measure the benefits to older people, care homes and Authorities of advocacy services being provided to older people entering or living in care homes as well as the cost of providing such services"*.

Many academic studies of advocacy for older people have been published; but a full literature review is beyond the scope of this review. However, the GB context has been examined and it shows that advocacy requires a more strategic approach<sup>2</sup>. The local context is described below.

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<sup>1</sup> Office of Fair Trading - Care Homes for Older People in the UK, A market study, May 2005, OFT780

<sup>2</sup> Commissioning Advocacy for Older People: A Common Lack of Approach?  
<http://www.opaal.org/Libraries/Local/830/Docs/Commissioning%20Report.pdf>

## 1.3 Policy Context

The project was undertaken in the midst of major political change for Northern Ireland with the restoration of the Northern Ireland Assembly on 8 May 2007. Alongside this, there was also major organisational change within Health and Social Care in Northern Ireland with the reformed Health and Social Care Trust structure coming into place in April 2007. The Health and Social Services Councils were in a transitional process that could lead to them being replaced by a single Patient Client Council in April 2009. The Regulation and Quality Improvement Authority was established in April 2005. One of the functions of the Authority is to monitor and inspect a wide range of services delivered by health and social care bodies and by the independent sector and to encourage improvements in the quality of those services against minimum standards. The minimum standards for residential/nursing homes were issued by DHSSPS in January 2008.

At a policy level the role of advocacy has been increasingly acknowledged in recent years. For example, the National Institute for Clinical Excellence and Social Care Institute for Excellence jointly issued guidance for supporting people with dementia and their carers. This guidance covered the importance of advocacy services and other voluntary support services. Under the Mental Capacity Act 2005, there is a legal requirement for people lacking mental capacity to have an independent advocacy service. In England and Wales a service specification for such a service has been drawn up.

There were a lot of changes taking place in terms of the organisational governing structures and in the management and direction for some residential nursing services for older people across Trusts. Although this presented difficulties for the Steering Group, it also offered the potential to influence the way in which emerging organisations approach the issue of advocacy for older people.

Given the starting point for the project, it is important to note the DHSSPS response to the Office of Fair Trading Care Homes Market Study.

*"The provision of advocacy services is key to ensuring that people not only have access to the complaints procedure, but also feel able to make use of it. This recommendation is based on the concern that most advocacy organisations are too small and cannot undertake the necessary cost/benefit analysis needed to compete for central government funding so that their service can be offered to more people. The pilot study recommended is intended to*

*provide this data in order to secure future funding of advocacy services. The situation is different in Northern Ireland because advocacy is provided in a more structured way by Health and Social Services Councils and large voluntary organisations such as Age Concern and Help the Aged which receive funding from the Department. With this in mind, the Department feels that the most appropriate action is to work with other UK health departments to establish the benefits of these existing advocacy services before committing further investment."*

Given this response, the Steering Group judged it important to assess the reality of current access to advocacy services for older people in care homes and to seek to identify key actions arising from a broad evidence base. There was also concern about the interchangeable use of terms such as 'advocacy' and 'complaints'. The relationship between advocacy and the complaints process is arguably at its strongest when there is potential for timely advocacy to lessen the number of complaints made by improving communication and supporting immediate resolution of difficulties. However, advocacy is a different approach to the use of a complaints process. The Department of Health, Social Services and Public Safety statement refers to the Health and Social Services Councils as a provider of advocacy services alongside the large regional voluntary organisations. The legislation relating to the Health and Social Services Councils charges them with supporting service users in complaining about health and social care services. The Health and Social Services Councils also have a general advocacy role in representing the public interest in relation to services. It is only in recent years, and without additional resources, that the Health and Social Services Councils have begun to develop an advocacy service for individuals. However, the Health and Social Services Councils are conscious that the provision of advocacy for older people in care homes is a substantial task. It can also require specific skills for various client groups e.g. learning disability. Currently some advocacy services are provided in an *ad hoc* way within care homes and in some areas by statutory and voluntary organisations. However, this does not equate to a consistent, accessible and independent service.

The Steering Group believed that they should begin to tease out some of these complex issues to clarify what is currently happening and to help the new Health and Social Care organisations effectively deliver advocacy services.

## 1.4 Method Used For The Review

The review process was supported by a Steering Group the composition of which is at Appendix 1. Their role was to provide strategic direction to the project. An implementation and governance sub-group managed the detail of the work.

The Steering Group initially produced a Project Initiation Document to set out various stages and timescales for the additional delivery of the project. This document was then used to guide the project through the various stages of the project, which are set out below:

- Agreed definition of advocacy.
- Agreed the methods used to gather data.
- Mapped location/type of homes.
- General desk research and information gathering.
- Questionnaires sent to all registered care homes.
- Held a residents' focus group.
- Held a relatives' focus group.
- Held a reference group for stakeholders.
- Hosted a seminar of all interested parties to comment on initial findings.
- Sought an expert review of outputs.
- Produced a final report including recommendations for policy and practice.

## 1.5 Defining Advocacy

The Steering Group agreed to adopt the following definition of 'advocacy':

“Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon.” *(Scottish Independent Advocacy Alliance)*

A key part of the project was to explore whether there was a shared understanding of, and definition of, advocacy across project stakeholders.

## 1.6 Audit or Research?

The Steering Group carefully considered whether the project involved audit or research and the respective ethical implications. In general terms, an audit

methodology involves a systematic examination of performance against a set of criteria whilst research refers to the gathering of new knowledge. Given the objectives of the project as set out above, the Steering Group determined that this was an audit process to measure what was currently happening in terms of advocacy. One difficulty was the lack of agreed standards or criteria for advocacy. The Steering Group was also conscious of the sensitive nature of the subject matter and charged the implementation and governance sub-group with ensuring that, at all stages of the project, ethical issues were screened and dealt with appropriately.

## **1.7 Standards**

As part of the initial information gathering, the Steering Group sought out the existence of commonly agreed standards in advocacy. Whilst there did not appear to be Northern Ireland or even UK-wide standards, there was a similarity of themes. It was not possible to discover standards relating specifically to older people in care homes. It was finally agreed to adapt Buckinghamshire County Council's advocacy<sup>3</sup> standards as the basis for the questionnaires and focus group discussions throughout the project. It is recognised that further research may reveal alternative standards or models for advocacy to inform further development.

## **1.8 Seminar**

A key piece of the information gathering process was to bring all interested parties together to debate the audit findings and highlight the significant issues. The one-day seminar took place on 13 June 2007 and was attended by over 100 people including:

- independent care homes owners, managers and staff,
- staff and managers from statutory homes,
- care home inspectors from Regulation and Quality Improvement Authority,
- service commissioners,
- voluntary sector representatives,
- HSSC members and HSSC staff.

After hearing the findings from the audit, the participants broke into small working groups to answer the following questions:

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<sup>3</sup> [www.bucksc.gov.uk](http://www.bucksc.gov.uk)

- Has the case for advocacy been made?
- Do we need standards?

A summary of the issues highlighted by these working groups is included in the report and has influenced the development of the report recommendations.

Participants also had an opportunity to make individual comments on a Graffiti Wall. Some of these comments are included in Appendix 3.

**Conclusion:**

- **It is widely accepted that there is a need to develop joined up working across the new post-Review of Public Administration Health and Social Care organisations. In particular the responsibilities of the proposed Patient Client Council in relation to care homes and its role with regard to advocacy.**
- **A more strategic approach to advocacy services in care homes is needed if residents are to have access to appropriate types of advocacy to meet their needs in different situations. This should recognise the relative merits of advocacy provided by care home staff and other professionals as well as other models such as independent advocacy.**

## 2 CARE HOMES

### 2.1 Care Homes Audit

Early in the project a questionnaire was devised based upon standards developed by Buckinghamshire County Council. This questionnaire (Appendix 2) was sent to the 594 registered and statutory homes for older people across Northern Ireland.

Two hundred and thirty completed questionnaires were returned representing a response of 39%.

|               |    |
|---------------|----|
| Eastern area  | 88 |
| Northern area | 60 |
| Southern area | 42 |
| Western area  | 40 |

The findings of the audit are set out below:

### 2.2 Definition of Advocacy

From a number of definitions offered, 53% of respondents agreed with the statement “Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon”.

### 2.3 Does your care home provide advocacy arrangements for patients and residents?

120 care homes (52%) said they had advocacy arrangements in place. 80 of these 120 said they provided advocacy themselves. Some homes provided information on how they did this.

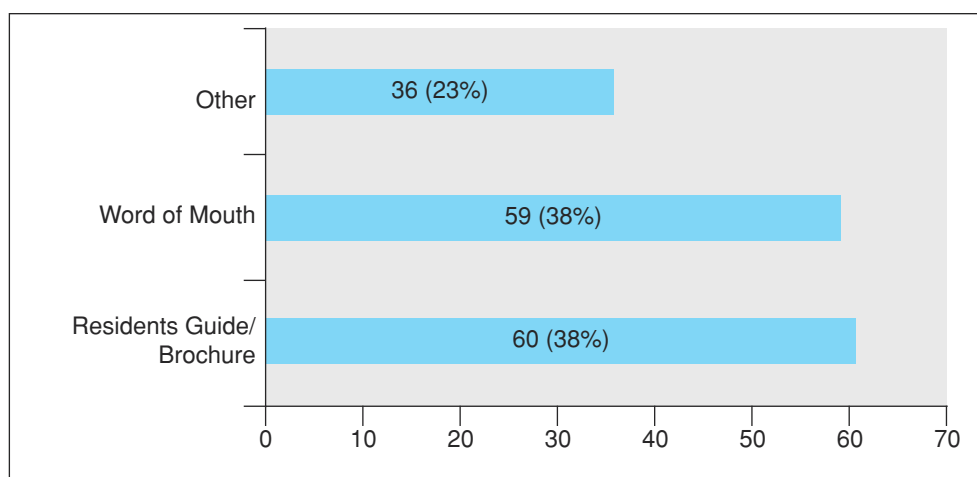
The most popular means by which advocacy was provided is shown below:-

|                        |    |
|------------------------|----|
| Care Home/Care Manager | 24 |
| Relatives Meetings     | 19 |
| Residents Meetings     | 19 |
| Named Nurse            | 18 |
| Care Staff Assistants  | 13 |
| Care Review / plans    | 11 |
| Named Care Worker      | 10 |
| Social Worker          | 9  |
| Annual Survey          | 6  |
| Bryson House           | 6  |
| RQIA Inspectors        | 6  |
| Age Concern            | 4  |
| Chaplaincy             | 2  |
| Local Councillor       | 2  |

In some individual cases advocacy was provided by other organisations or individuals such as Health and Social Services Councils, Relatives Association, Mencap, Care for the Blind, Psychiatrist, Alzheimer’s Society, Help the Aged, their GP, Voluntary Service Bureaux, Rethink, etc

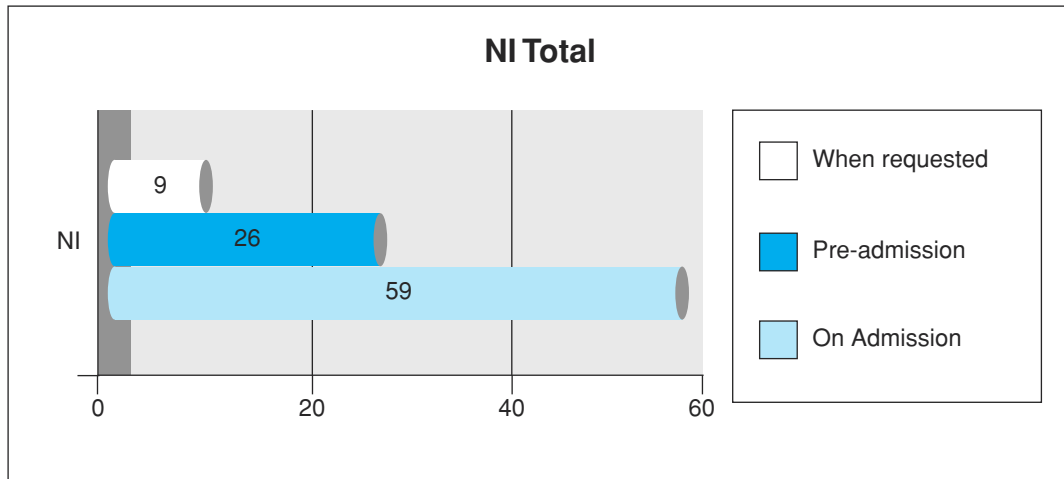
## 2.4 How do residents / patients receive information on advocacy?

The main vehicle quoted by the care homes for providing information about advocacy was the residents’ guide/brochure followed closely by ‘word of mouth’. In a few cases other means of communicating advocacy was cited eg residents meetings (7), notice boards (5), The Relatives Association (5)



## 2.5 When do residents receive this information?

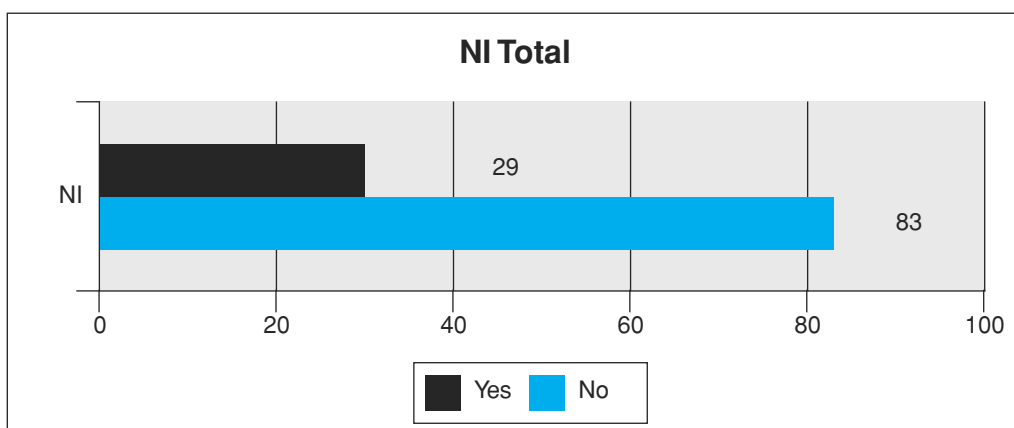
Bearing in mind that the main method of providing this information is through the residents' guide and/or by word of mouth then the responses showed that residents received the information primarily 'on admission' or to a lesser extent 'pre-admission'.



In a fewer number of cases the information is supplied 'on request'.

## 2.6 Do carers/relatives also receive information on advocacy?

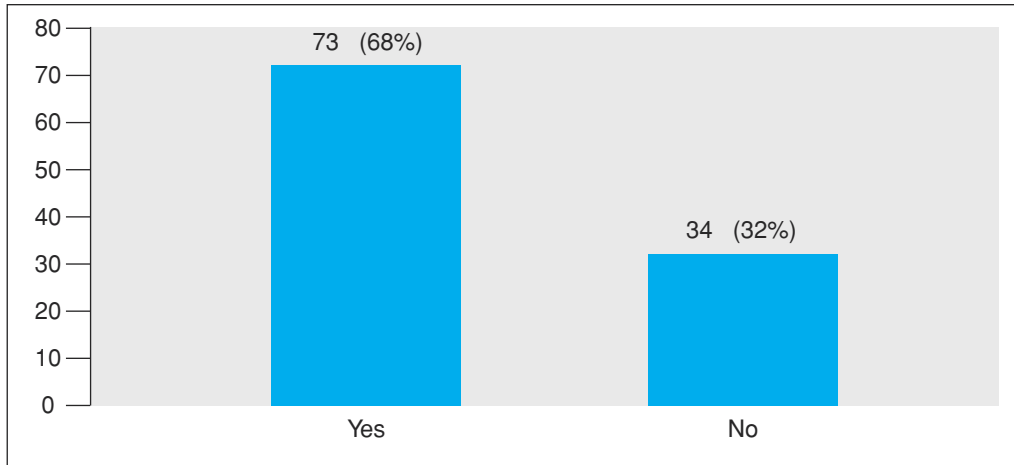
Almost 70% (83) of care homes providing advocacy information stated that they also provided this to carers and relatives.



## 2.7 Would residents know how to contact an advocate?

Seventy three care homes (68%) felt that residents would know how to contact an advocate. They based this on information shared by means of the following:

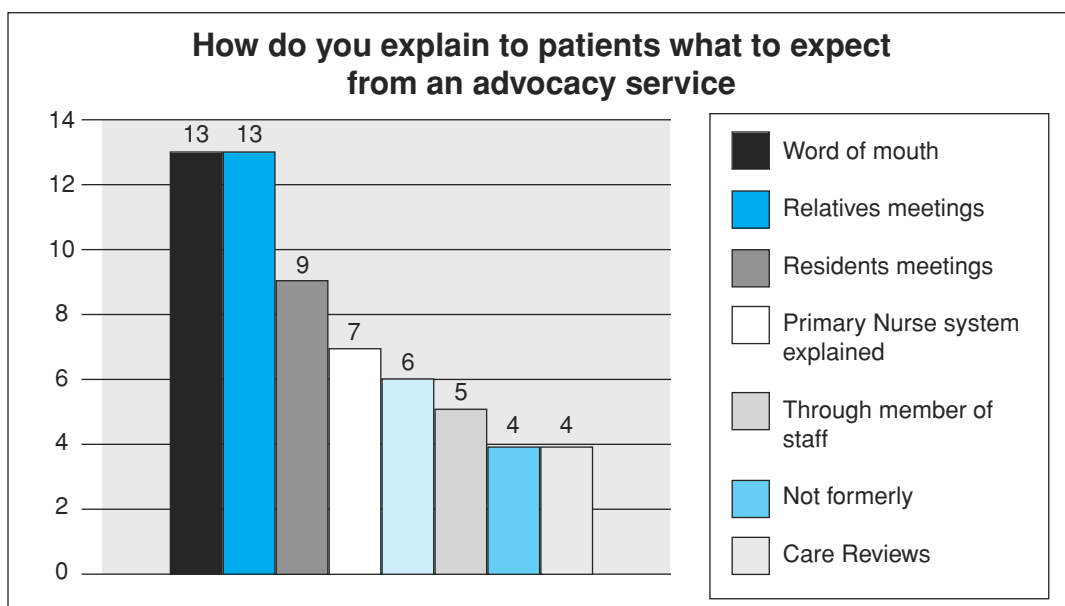
- Carers Support group
- HSS Council leaflets
- Residents charter
- Newsletter



## 2.8 Do you explain to residents what to expect from an advocacy service?

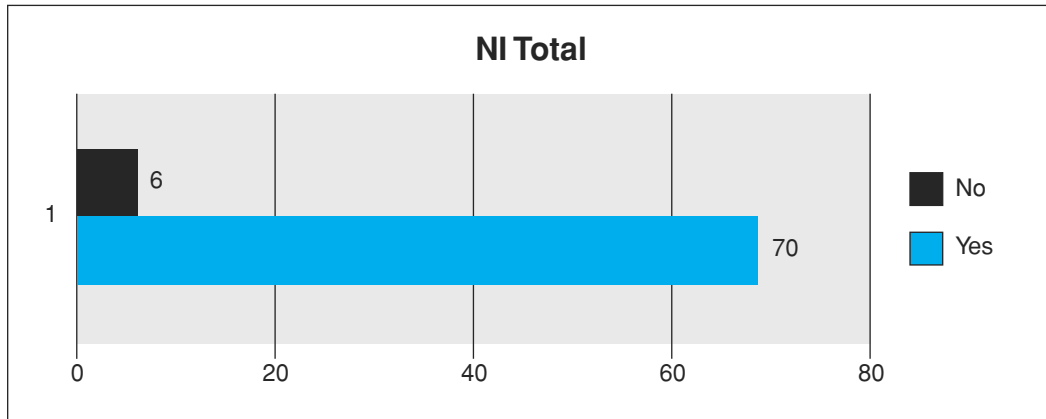
The majority of homes (58%) did seek to explain to residents what they should expect from an advocacy service.

The main responses referred to word of mouth explanations and through meetings with relatives and meetings with residents. There appeared to be little formal means of explaining this with responses including 'If patients enquire' and 'Have never been asked'.



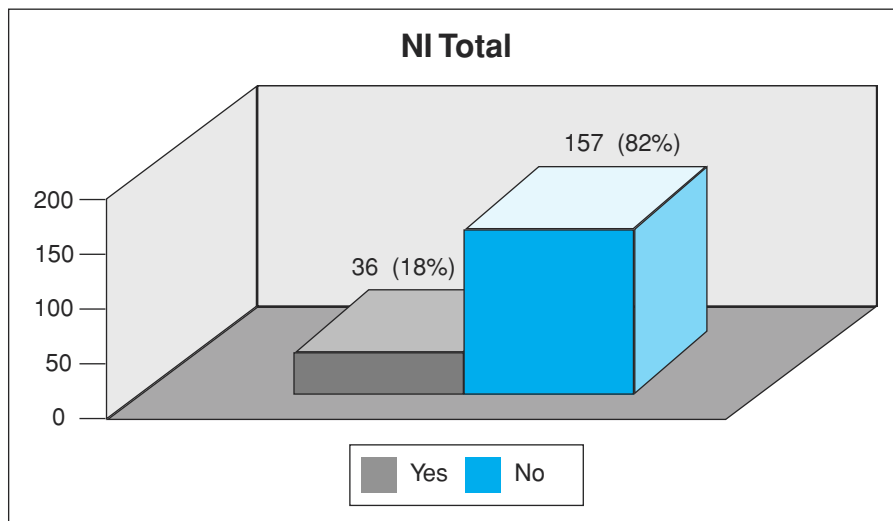
## 2.9 Would the care home find advocacy arrangements useful?

This question was directed at those homes not providing advocacy. Of the 76 care homes who responded to this, 92% (70) said they would find it useful.



## 2.10 Is advocacy information publicly displayed within the home?

Information on advocacy was not routinely displayed in homes.



Where displayed this information took various forms, the most popular being:

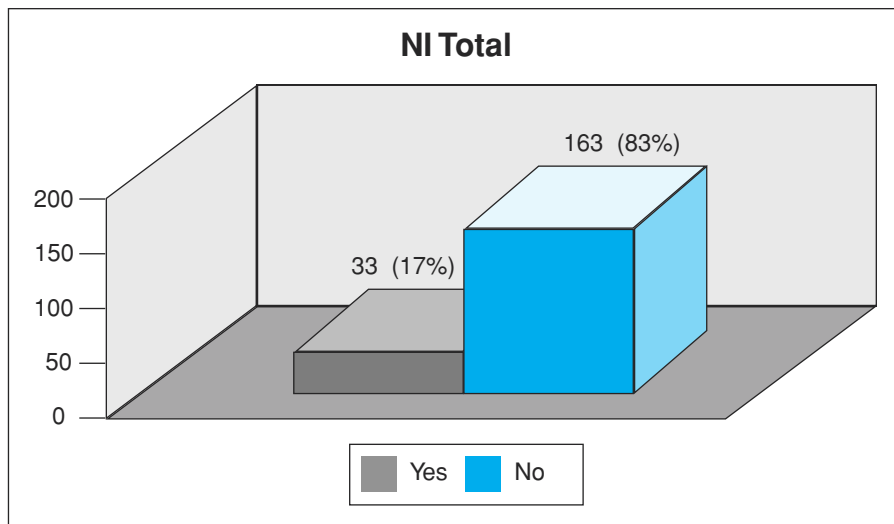
- Residents' Guide
- Complaints procedure
- Relatives Association leaflet
- Poster

- Statement of purpose
- Named key worker

However, in total, these methods were used in less than one fifth of responses (see figure, above).

## 2.11 Does the care home provide advocacy training to staff?

Seventeen percent (33) of care homes provided training for staff in advocacy. 83% did not.



It was not usual practice to provide advocacy training to staff. Where it was provided, the most commonly quoted method was through staff induction (53%).

## 2.12 Access to patients'/residents' records

One hundred and fifty four care homes (78%) said they had a procedure for patients/residents to access their personal care records. However, 16% (24) of 154 stated that they allow access only if requested.

**Conclusion:**

- **The 39% return rate for the postal questionnaire and the good attendance at the follow up seminar showed a positive interest and engagement from the care home sector.**
- **Over half of care homes agreed on a common definition of advocacy.**
- **Currently advocacy can be provided by a range of independent providers. There was no evidence that the providers shared common standards or whether input was provided on a one-off/occasional basis or on a longer term, sustainable way.**
- **Most care homes providing advocacy arrangements did so in-house and see advocacy as part of their core work.**
- **The main ways of informing people about advocacy was through printed Residents' Guides or by word of mouth before or at the time of admission. In some cases information was on display in the home.**
- **Homes that did not believe that they offered advocacy services indicated a high level of interest in putting arrangements in place.**
- **Care home managers were of the view that residents (and their relatives) would know how to go about accessing advocacy.**
- **Where staff training in advocacy is provided, it is delivered primarily through staff induction.**

## 3 FOCUS GROUPS FOR RESIDENTS

### 3.1 Introduction

Focus groups were held in 9 establishments across Northern Ireland<sup>4</sup>. These groups were independently facilitated with support from HSSC staff and represented homes from the independent, statutory and voluntary sectors.

|   |   |
|---|---|
| Independent (private) nursing homes       | 5 |
| Independent (voluntary) nursing home      | 1 |
| Statutory residential home                | 1 |
| Independent (voluntary) residential homes | 2 |

The categories of care the homes were registered for included old age, dementia, physical disability and learning disability.

### 3.2 Method

A total of 59 residents participated in the exercise, the majority within focus group settings and the remainder in individual interviews where this was judged to be more appropriate. The size of the focus groups ranged from 4 to 13 residents in each group.

Participation in the focus groups was entirely voluntary and relied on the co-operation of managers who helped organise the residents into groups and those residents willing to participate either in groups or individually expressing their views.

The arrangements for the focus group were as below:

- Care homes across the region and in various categories were contacted inviting participation in focus groups. The 9 homes which responded positively agreed to suitable dates for visits by the group advisors.
- A set of questions was compiled to reflect standards and an aide memoir was designed to assist in the recording of information elicited from the groups.

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<sup>4</sup> Details of how to access the 'Report of findings from 9 focus groups for residents in residential care and nursing homes held during January/February 2007 can be found on Appendix 4.

- A protocol was established for the management of any disclosures or complaints raised by residents in the group or interview setting.
- The definition of advocacy which was adopted as most appropriate for this exercise was the following:

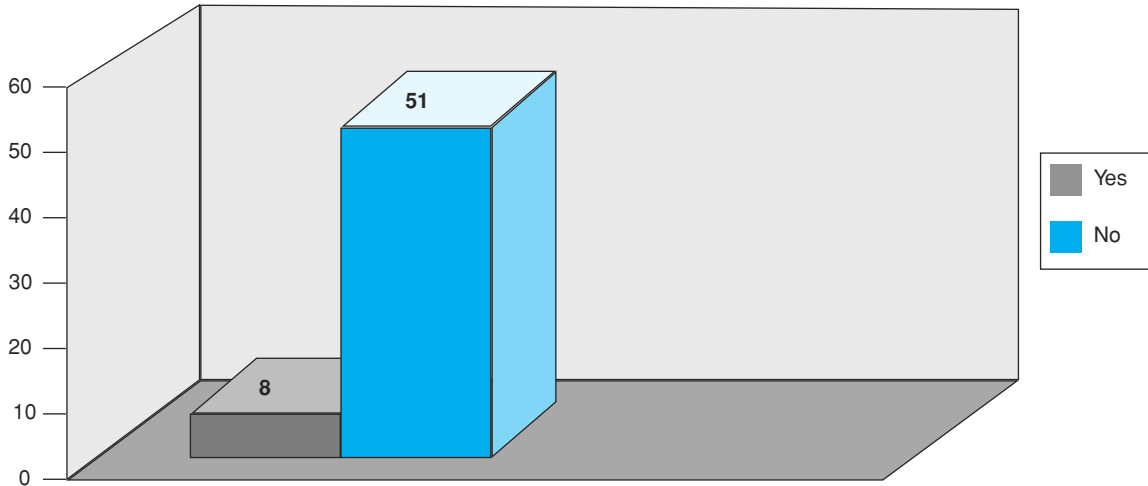
*“Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon”. At the start of each meeting the group advisor endeavoured to give further definition of an advocate along the lines of “someone who will listen to your concerns and act on your behalf, who is not part of the running of the home”.*

- When residents shared concerns in the group, the advisors, with the permission of the resident/s, brought their issues to the attention of the manager, ensuring anonymity where appropriate.
- Each session lasted for at least 1 hour depending on the engagement with the group. When time allowed the advisors engaged in wider topics thus stimulating reminiscence and encouraging participation. In one home 6 residents preferred to be interviewed individually in the privacy of their rooms, while in another 4 were engaged in discussion in a communal lounge with a visiting husband speaking on behalf of his severely disabled wife. In a unit for elderly mentally infirm residents a single resident was interviewed in the visitor’s room.
- General feedback was provided to the managers informing them how the groups had functioned and, where permission had been given by the group, any concerns were passed on for action by the manager.
- Managers were informed of a proposed seminar later in the year, to which they would be invited to hear the results of the audit.

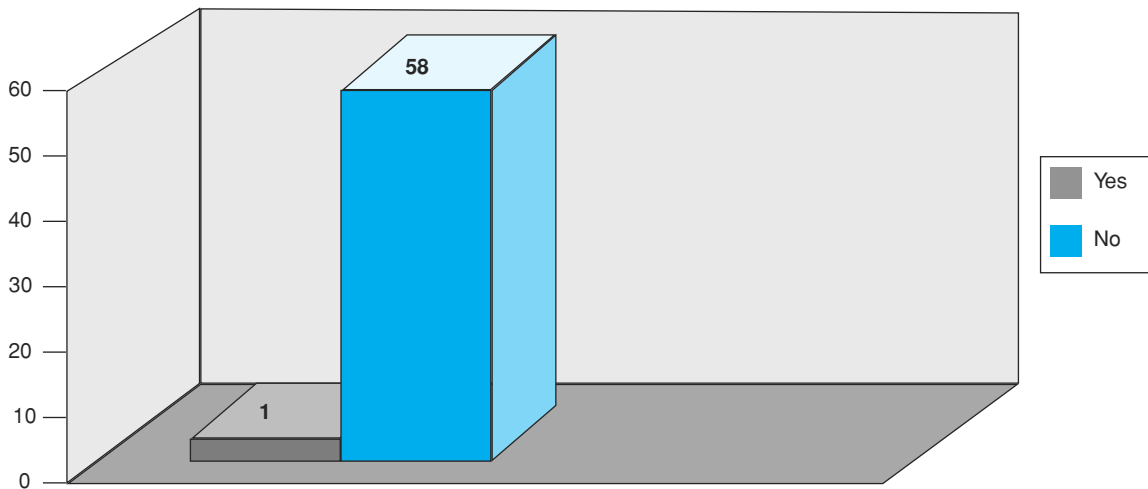
The findings are set out below.

### 3.3 Findings from focus groups

#### 3.3.1 Have you received information about advocacy arrangements for residents?



#### 3.3.2 Did you receive this information from the home?



#### 3.3.3 How did you receive this information? (eg in a leaflet)

Six residents in a home registered for learning disability had received a personal letter from Bryson House describing the advocacy service provided. A resident in the nursing home which has engaged in a pilot project named Bryson House but was not sure how she had been informed.

### 3.3.4 Would you know how to contact an advocate?

Those who indicated that they would know how to contact an advocate, named the following people or organisations.

|                         |    |
|-------------------------|----|
| Member of family.       | 20 |
| Manager of the home.    | 19 |
| Member of staff.        | 10 |
| “Wouldn’t know.”        | 3  |
| Voluntary Organisation. | 1  |
| “Not staff”             | 1  |
| Social worker.          | 1  |
| Services Manager.       | 1  |
| Lawyer.                 | 1  |
| Priest.                 | 1  |
| G.P.                    | 1  |
| Totals                  | 59 |

### 3.3.5 What would you expect from an advocacy service?

There was a wide response to this question. Six residents did not see a need for advocacy due to their confidence in the staff teams. This was reflected in comments such as, *“I can’t think of anything - home takes care of everything.”* *“I can’t see me using it because the staff here are so good”*.

*One resident suggested that “Advisory Service” was simpler to understand than “Advocacy Service” adding “you would not need to go beyond the staff in this home”.* One resident was confident that his executor would deal effectively with any of his concerns. However, other residents articulated the following expectations:

- Deal with concerns eg such as quicker response to the buzzer.
- Ask about care eg how are you keeping?
- Speak up for you eg if rules were unreasonable.
- Give advice about medication - one resident was in pain and felt that her medication could be increased.
- Provide information/clarification - *“if you don't understand something”*.

- Ask about facilities eg buzzer not working, need for an extra toilet.
- Financial advice eg "what happens when my capital runs out?"

In one home 4 residents equated the question with complaining and claimed they were not aware of the complaints procedure although they confirmed they were "happy" with the level of care provided. However, they commented on the poor standards of the male residents' behaviour eg spitting.

During discussion a resident poignantly drew attention to the fact that she "had no family and felt it". She appreciated the advocacy being provided to the home and thought it was a good idea as "it showed someone had an interest."

In 2 homes already receiving an advocacy service the residents knew their advocates by name and valued their input, commenting positively about the service.

### **3.3.6 Is information on advocacy publicly displayed in the care home?**

All of the residents confirmed that they were unaware of any information on advocacy on display. However, 1 resident referred to a complaints leaflet.

### **3.3.7 Have you ever needed to use an advocate? If yes, (a) were you given a choice of advocate? (b) Did you find the advocate helpful?**

Fifty three (95%) of the residents claimed not to have ever needed to use an advocate.

The husband of one resident spoke to the group advisors and was clearly acting as his wife's advocate. He had received useful information about Power of Attorney from the Alzheimer's Society.

Two homes in the Eastern Board area were receiving an advocacy service from Bryson House. The residents in these homes spoke favourably of the advocates visiting the homes. They spoke about them as people they trusted and had faith in. *"Very helpful (information), like*

*talking to her, shows interest” “She would help and always asks if everything is all right.*

One resident was confident that his “Executor” was capable of dealing with any issues that might arise.

**3.3.8 Can you list 3 positive aspects and 3 things that could be improved in your experience of advocacy?**

The following table reflects the difficulty the majority of residents had with this question both in focus groups and in individual interviews.

| Positives         | Improvements   |
|-------------------|--|
| Keyworker         | Resident could go to advocate rather than advocate coming to the home. |
| Information       | Good for people who have no family member.                             |
| Choice of Home    |  |
| Interest in us    |  |
| Meetings          |  |
| Might be useful   |  |
| More independence |  |
| More satisfaction |  |

**3.3.9 Have you been informed about how to access your personal records held in the care home?**

In 7 out of the 9 homes visited, the residents were not aware that they could access their personal records. In one focus group of 13 residents, 2 were aware of this right. The manager in one home (learning disabilities) said that all the residents knew where their records were kept and could access them on request at any time.

**3.3.10 Do you think it would be useful to have advocacy arrangements in place in the home, and if so under what circumstances would you consider using it?**

Twenty residents thought it would be a good idea to have an independent advocate while 20 did not. Two residents were not sure and the remainder did not commit to a view.

The main reason for thinking it was not a good idea was confidence in their existing family network or staff in the home. One resident would not

want a neighbour or a stranger. Another commented *“Don’t see a need”*. The following quotes supported some of the yes vote:

- *“Good idea especially if some person had no-one.”*
- *“Satisfaction re complaint.”*
- *“Probably helpful, people would be able to raise a complaint.”*
- *“Good to know someone outside the home cared.”*
- *“Certainly”*
- *“Yes but can’t see it being used a lot”*
- *“Would be a good thing, sometimes it takes someone outside to do things for you.”*
- *“If ..... (Voluntary Organisation) could not deal with it satisfactorily.”*
- *“Prior to admission, information about choices and selling the house.”*
- *“Sure it would be a good thing if you needed help.”*
- *“Good idea opens new doors.”*
- *“Questions could be asked (about standards).”*

### Conclusion:

- There was a lack of awareness of advocacy and information for residents.
- Not all residents felt the need for an advocacy service believing that their support needs were already being met.
- Good staffing levels appeared to improve the 'listening culture' of the care home.
- The role of relatives and staff was valued as a source of advocacy indicating the primary need to focus advocacy work on residents without close family.
- In care homes where there were independent advocates, this service was valued by the residents.
- The needs of residents with dementia and learning disability require particular attention due to their special needs and communication challenges associated with their conditions.
- The reluctance of residents to complain or make requests eg for privacy in making telephone calls/commenting on slow responses to requests for attention to basic needs, was noted in several groups.
- Accessibility to medical and related services such as GP/ podiatry, is likely to be an issue for advocates who would need a good knowledge of how such services work and how residents can avail of them.
- Group work may not always be an effective way of relating to all residents.
- Advice on the financial implications prior to admission to a care home appeared to be an important issue.

## 4 FOCUS GROUPS FOR RELATIVES

Within the study it was important that the views of relatives, carers and representatives were sought including relatives of people in both nursing and residential homes across Northern Ireland<sup>5</sup>.

It was acknowledged that not every resident had close relatives, or for various reasons, had close relatives who visit them regularly.

### 4.1 Method used

Focus groups were arranged in ten care homes and each of the group discussions were facilitated by the Relatives Association Northern Ireland supported by Health and Social Services Councils' staff.

A total of 73 relatives were involved in the groups with a good mix of male and female.

The discussions were fairly informal but had a focus on a number of key areas:

- what relatives understanding of advocacy was
- who might be regarded as an advocate
- what information was provided by homes in regard to advocacy
- past experiences of using advocacy services
- issues where relatives felt advocacy support would be beneficial.

To begin the discussion a number of definitions of advocacy were explored so that people could agree or disagree, use parts of definitions or come up with their own.

The consensus view was that advocacy was about:

*'speaking or acting on behalf of someone else, so that they may be heard and have their concerns acted upon'.*

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<sup>5</sup> Details of how to access the 'Report of findings from 10 focus groups for relatives in residential care and nursing homes held during January/February 2007, can be found in Appendix 4.

## 4.2 Who might be an Advocate?

A wide range of suggestions were put forward. The most commonly named organisations or professions were:

- Health care professionals (social workers, GPs, nurse)
- People close to the resident (relatives, carer, minister of religion)
- Organisations (Health and Social Services Council, Relatives Association, Regulation and Quality Improvement Authority)
- Staff employed within the care home (manager, staff member)
- People with authority (MP, Solicitor)
- Unidentified individuals (someone neutral/impartial, someone accessible to meet with)

Six of the ten groups mentioned the resident social worker, the general practitioner was mentioned by four groups as was the Health and Social Services Council.

Relatives of the person in care were only mentioned by a small number of the groups. It is not clear whether they did not feel sufficiently empowered to take on the role of advocate. However, in three groups relatives spoke of their reluctance to speak out because of a perceived fear of repercussion.

Whilst none of the participants in the focus groups could recall being given advocacy information, or seeing such information on public display, they said they had been encouraged by staff to raise issues directly with them.

## 4.3 What should an Advocacy Service look like?

Relatives primarily sought a service which was accessible to them. They had no particular preference as to how the service was structured e.g. regionally or locally.

They felt that the service should be impartial and should have the power to act upon issues raised. The service should be recognised and given due regard by the homes.

Those providing the advocacy service should be knowledgeable in their area of work, have the ability to listen, be honest, approachable and act with integrity.

## 4.4 When might an Advocacy Service be used?

The relatives suggested when they might turn to an advocacy service for assistance and support.

It was commonly agreed that it was important that an environment should exist where everyone would feel comfortable about approaching a care home manager in the first instance who would listen and seek to resolve issues. If satisfaction was not achieved then, relatives felt that contact with an advocacy service could be made.

Relatives also took the view that, with what they regarded as more serious issues, the support of an advocacy service would be of benefit in ensuring the problem was dealt with. In teasing out what they regarded as more serious issues the relatives suggested:-

- mistreatment of their relative
- harassment or bullying by other residents
- medication issues particularly where medication is given to subdue a relative
- attention by the home to personal hygiene or cleanliness of the resident
- attention to ensure a resident is properly fed

Relatives also felt that advocacy would be helpful where there was a poor relationship between the relative and the care home manager or when issues had been brought to the manager's attention but nothing had changed.

Many relatives of residents were themselves older people and expressed the view that it wasn't in their nature to complain, so would value the support an advocacy service would give them and increase their confidence in having issues of concern addressed.

## 4.5 The Way Forward

Relatives strongly supported the view that the care home should be given every opportunity to hear and act upon concerns in the first instance. However, they made a number of suggestions on the way forward.

- As a means of accessing information and clarifying their position relatives felt that it would be useful if there was a well publicised **Helpline** available to them. This would act as a support to them where

they could air concerns, be advised of their position and any appropriate legislation, conditions, etc applicable to the issue in hand.

- Relatives did not generally have any forum to share information, discuss issues, support each other or generally get together. Where there was an interest and support for this within a care home they felt that the setting up of a **Relatives Group** would be useful. The Group would be organised and run by relatives and may meet within, or outside of the care home at times and at such frequency as decided by the relatives.
- There was support for a staffed **Advocacy Service** to cover a number of homes within a geographical area. It was suggested that the service might set up for example monthly **Advocacy Clinics** which would be well publicised in advance.
- As the resident population changes and new relatives come on board it was felt that an **Information Pack** should be produced and be available through health and social care staff. Included in this pack would be information and contacts about the Advocacy Service.

#### **Conclusion:**

- **There was some difference of opinion between relatives and care home providers regarding who should provide advocacy services.**
- **Relatives favoured more independence in advocacy services.**
- **Relatives showed some reluctance to put themselves forward as the main advocate.**
- **While care homes stated that advocacy information was available and displayed, relatives did not recall seeing this.**
- **Relatives supported an accessible, impartial advocacy service staffed by knowledgeable people with power to act.**
- **It was felt that care homes should be approached in the first instance where there was a concern but that advocacy services might be advised where care home staff took no action or in the case of 'serious' issues.**
- **Some other useful suggestions were put forward which relatives would find helpful e.g. a telephone helpline, relatives groups, advocacy clinics and an information pack.**

## 5 **STAKEHOLDER REFERENCE GROUP**

In reviewing advocacy arrangements within residential and nursing homes in Northern Ireland it was important to seek and capture the views of some of the stakeholders within the voluntary and community sector. Such groups are often approached when people need advice or help and support when issues arise.

A Stakeholders Reference Group assisted the project meet its objectives. Voluntary organisations, churches and political parties were invited to attend. Organisations which participated were:

|                                    |                                 |
|------------------------------------|---------------------------------|
| Help the Aged                      | Age Concern                     |
| Women's Aid                        | Action on Elder Abuse           |
| Irish Advocacy Network             | Mencap                          |
| Presbyterian and Catholic Churches | Bryson House                    |
| Sinn Fein and Alliance Parties     | Workers Educational Association |

In discussing advocacy, stakeholders described it as:

‘Advocacy in its broadest term means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon’.

The majority of groups felt they provided some degree of advocacy or in a few cases signposted people to organisations that could help.

### 5.1 **Effectiveness of Advocacy**

The stakeholders gave examples of how advocacy could be effective:

- Residents and relatives may feel supported to be more open and the process can be less intimidating.
- May help to make care homes aware of issues.
- May help build good working relationships with home inspectors.
- Residents may have direct input on issues such as food, laundry, activities and outings.

## **5.2 Barriers to Effective Advocacy**

There may be a number of barriers which prevent advocacy being at its most effective.

The first of these is a general misunderstanding about what advocacy is actually about. While the definitions used in this report help explain advocacy the term on its own is not easy to grasp for most people and particularly so for the elderly.

A number of other barriers to effectiveness identified by the group are listed below:

- A general reluctance to complain.
- Lack of awareness of rights.
- Lack of funding available for advocacy in Northern Ireland and therefore limited capacity to provide a service.
- Advocacy is resource intensive and requires a quality service based on trust especially for people who are vulnerable or may have communication difficulties.
- Initial resistance to advocacy may come from service providers.

## **5.3 Essential Elements of a Good Advocacy Service**

Recognising that such barriers may exist, the stakeholders were asked to give their views of the elements they felt were needed for a good advocacy service.

They recommended the following:

- A service that is independent of service providers, confidential, accessible to all and free to the user.
- The service should be delivered by full-time paid advocates who provide advocacy on a personal and one-to-one basis.
- A strict code of practice should apply.
- A high level of awareness and promotion to residents with positive encouragement to engage in the process.
- The provision of training and support to empower residents and others so that they can speak up for themselves and others.
- The service should be independently monitored.

## **5.4 How to Make Advocacy Work**

In order to be effective for those people the service is aimed at, the group stated strongly that there is the need to work in partnership with the providers of services and foster and maintain positive and harmonious working relationships between the advocates and the care homes. It was also suggested that good practice or exceptional caring services should be highlighted and promoted.

There was also the need to ensure that the service users' expressed needs and wishes, formed the advocacy agenda and were the focus of all actions undertaken on their behalf.

### **Conclusion:**

- **Stakeholders viewed their own advocacy arrangements in a positive light.**
- **They felt advocacy is most effective in supporting people to speak out and put forward their views.**
- **Work is required in understanding and promoting the advocacy role.**
- **Barriers to advocacy include, lack of awareness, funding and resistance from providers, and reluctance to complain.**
- **The concept of an independent, accessible, confidential service with trained staff operating within a strict code of practice was supported.**
- **Advocacy services should be well publicised and free to the user.**
- **Effective advocacy would be delivered according to an agreed guideline in partnership between users, carers and service providers.**

## 6 KEY MESSAGES FROM SEMINAR

On 13 June 2007, over 100 people came together to hear and discuss the findings of the audit process. Participants came from all the geographical areas covered by the audit and included representatives of independent and statutory care homes, voluntary organisations, commissioners, Health and Social Care Trusts, Regulation and Quality Improvement Authority representatives and members/staff of the Health and Social Services Councils.

The participants broke into small working groups to consider two questions. *Has the case for advocacy been made? Do we need standards?*

The main messages coming from this event are set out below:

1. There was consensus that advocacy is a key element of the services required by older people in care homes.
2. The term 'advocacy' is not always understood. It is important to define it operationally, promote it publicly and increase accessibility.
3. The role of independent advocacy services is important.
4. Standards would enhance the development and understanding of advocacy.
5. The development of standards should reflect the existing advocacy charters, Department of Health, Social Services and Public Safety care standards, National Institute of Clinical Excellence guidelines, etc.
6. There is a need to have a clear, evidence base about the impact of advocacy services.
7. Advocacy needs and solutions vary and "one size" will not fit all. There is a need to identify and provide information about relevant advocacy models, select suitable type(s) and then develop and promote induction and training. Toolkits are needed to assist in the promotion of advocacy.
8. Care home staff and other professionals were clear that advocacy is a core competency in their work and should not be disregarded in preference for independent advocacy.
9. There was an acceptance that there needs to be a choice of advocates for those that need them. Sometimes this will be a service provider or relative but sometimes it will be more beneficial and appropriate to have an independent advocate.

10. The cost of advocacy was highlighted, raising the question of how such a service could be funded in a sustainable way. On the other hand, Advocacy can support the delivery of safe and effective services and lessen the number of formal complaints.
11. Equity is also an issue. Some categories of patient/client are particularly vulnerable and may be more dependent on advocacy. Older people who have no close relatives may feel the need for advocacy support.
12. There should be monitoring and evaluation of the effectiveness of advocacy.

The seminar participants had the opportunity to leave comments alongside the collective discussions. A flavour of these are shown in Appendix 3.

## 7 CONCLUSIONS

### 7.1 Background to the Review

- There is a need to develop joined up working across the new post-Review of Public Administration Health and Social Care organisations. In particular the responsibilities of the Patient Client Council in relation to care homes and its role with regard to general versus specialist advocacy require further development.
- A strategic approach to advocacy services in care homes is required to allow residents to have access to different types of advocacy to meet their needs in different situations. This has to recognise the relative merits of advocacy provided by care home staff and other professionals as well as independent advocacy.

### 7.2 Care Homes and Advocacy Services

- The 39% return rate for the postal questionnaire and the good attendance at the seminar showed a positive interest and engagement from the care home sector.
- Over half of care homes agreed on a common definition of advocacy.
- Currently advocacy may be provided by a range of independent providers. There was no evidence that providers shared common standards or whether input was provided on a one-off/occasional basis or on a longer term, sustainable way.
- Most of the care homes which provided advocacy arrangements did so in-house and consider advocacy as part of their core work.
- The main ways of informing people about advocacy was through printed residents' guides or by word of mouth before or at the time of admission. In some cases information was on display in the home.
- Where homes did not believe that they offered advocacy services, there was a high level of interest in putting arrangements in place.
- Care home managers felt that residents (and their relatives) would know how to go about accessing advocacy.

- Where staff training in advocacy is provided, it is delivered primarily through staff induction training.

### **7.3 Residents' Focus Groups**

- There was a lack of awareness of advocacy and information for residents.
- Not all residents felt the need for an advocacy service believing that their support needs were already being met.
- Good staffing levels appeared to improve the 'listening culture' of the care home.
- The role of relatives and staff was valued as a source of advocacy indicating the primary need to focus advocacy work on residents without close family.
- In care homes where there were independent advocates, this service was valued by the residents.
- The needs of residents with dementia and learning disability require particular attention due to their special needs and communication challenges associated with their conditions.
- The reluctance of residents to complain or make requests eg for privacy in making telephone calls/commenting on slow responses to requests for attention to basic needs, was noted in several groups.
- Accessibility to medical and related services such as podiatry/GP, is likely to be an issue for advocates who would need a good knowledge of how such services work and how residents can avail of them.
- Group work may not be an effective way of relating to all residents.
- Advice on the financial implications prior to admission to a care home appeared to be an important issue.

### **7.4 Relatives' Focus Groups**

- There was some difference of opinion between relatives and care home providers regarding who should provide advocacy services.

- Relatives favoured more independence in advocacy services.
- Relatives showed some reluctance to put themselves forward as the main advocate.
- While care homes stated that advocacy information was available and displayed, relatives did not recall seeing this.
- Relatives supported an accessible, impartial advocacy service staffed by knowledgeable people with power to act.
- It was felt that care homes should be approached in the first instance where there was a concern but that advocacy services might be advised where care home staff took no action or in the case of 'serious' issues.
- Some other useful suggestions were put forward which relatives would find helpful e.g. a telephone helpline, relatives groups, advocacy clinics and an information pack.

### 7.5 Stakeholders' Reference Group

- Stakeholders viewed their own advocacy arrangements in a positive light.
- They felt advocacy is most effective in supporting people to speak out and put forward their views.
- Work is required in understanding and promoting the advocacy role.
- Barriers to advocacy include, lack of awareness, funding and resistance from providers, and reluctance to complain.
- The concept of an independent, accessible, confidential service with trained staff operating within a strict code of practice was supported.
- Advocacy services should be well publicised and free to the user.
- Effective advocacy would be delivered according to an agreed guideline in partnership between users, carers and service providers.

## 8 RECOMMENDATIONS

1. The DHSSPS should supplement the published Nursing and Residential Care Home Standards by adopting the following definition of advocacy as set out in this Report.

“Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon.” (*Scottish Independent Advocacy Alliance*)

2. The DHSSPS in their review of funding should explore the feasibility of the HSC delivering sustainable, independent, centrally funded advocacy services to people in care homes.
3. HSC commissioners and providers should continue to promote and facilitate an advocacy service model that is equitable, flexible, relevant and responsive to the needs of service users, building on existing regional expertise and best practice.
4. Service commissioners who contract for care services should ensure that the service specification includes a quality standard for advocacy, which should be measured and monitored.
5. HSC bodies should acknowledge and support the existing advocacy role of care home staff and other professionals.
6. RQIA, through its inspection process, will review compliance and make recommendations to providers to ensure access to advocacy is put in place.
7. Advocacy services should be free to the user and actively promoted and publicised by all providers.

## **9 ACKNOWLEDGEMENTS**

The Steering Group wishes to acknowledge the time and experience contributed to this project by so many. Particular thanks are due to residents and relatives who shared their views and experiences so openly, and to care home managers for completing and returning questionnaires. Grateful thanks are also offered to those managers who organised focus groups within their care home. The study was reviewed by Professor Brendan McCormack and Professor George Kernohan, members of the University of Ulster Recognised Research Group “Working with Older People.”

## **APPENDIX 1**

### **PROJECT STEERING GROUP**

Annie Burrell, Member, SHSSC

Betty Campbell, Member, EHSSC

Kate Comiskey, Chairman, Independent Providers

Stella Cunningham, Chief Officer, SHSSC

Richard Dixon, Chief Officer, EHSSC

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Nuala Gorman, Acting Deputy, Older People POC, Southern H&SC Trust

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Elaine Somerville, Development Officer, South East H&SC Trust, Lisburn

Lorraine Wilson, Inspector, RQIA



## APPENDIX 2



The **Regulation** and  
**Quality Improvement**  
**Authority**

### Review of Access to Advocacy for Care Homes in Northern Ireland

Questionnaire for Managers / Officers in  
Charge of Nursing and Residential Care  
Homes for Older Persons

## WHAT IS ADVOCACY?

Please have a look at the definitions of advocacy below and tick the one you agree with most or, alternatively, give us your description of what you think advocacy is.

NO. 1  
“Advocacy in its broadest terms means acting with or on behalf of service users and communities so that they may be heard and have their concerns acted upon.”

NO. 2  
“The active support of an idea or cause, especially the act of pleading or arguing for something.”

NO. 3  
“A campaign that an individual or organisation undertakes to promote or measure that which would broadly benefit society.”

NO. 4  
“It’s about sticking up for people who are at risk of being ignored or mistreated. It’s about helping people to find out what they want and telling others about it. It’s about making sure that people get to the things they enjoy and change the things they don’t like.”

NO. 5  
Please explain.

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

NO. 6  
Don't know

**Please tick the category of your home**

- Residential
- Residential (small)
- Nursing
- Nursing (residential beds)
- Statutory

---

1. Does your nursing/residential care home provide advocacy arrangements for residents/patients?

YES  If yes, who provides this service?

Nursing/residential care home  Other

Please explain how you provide it.

.....

.....

.....

.....

.....

.....

.....

.....

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Go straight to question 2

NO  If no, answer part 1(ii) and go straight to Question 7

1(ii) If no, would the nursing/residential care home find advocacy arrangements useful?

YES  NO

Now go straight to question 7

2. How do patients/residents receive information on advocacy? (e.g. in a booklet or patient guide, word of mouth)

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(If applicable, please provide a copy)

3. Do relatives/carers also receive a copy of this information?

YES       NO

4. When do patients/residents receive this information?

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5. (i) Would patients/residents know how to contact an advocate?

YES       NO

(ii) If yes, how do they know?

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(i) Do you as Manager of the nursing/residential care home explain to patients/residents what to expect from an advocacy service?

YES  NO

(ii) If yes, please give details

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6. Is advocacy information publicly displayed within the nursing/residential care home?

YES  NO

(ii) If yes give details below

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(i) Does your nursing/residential care home provide advocacy training to staff?

YES  NO

(ii) If yes, how often? Please give details.

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8. Does your nursing/residential care home have a policy and procedure for patients/residents to access their personal and care records in the nursing/residential care home?

YES

NO

If yes, how and when are patients/residents made aware of this? Please give details.

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The four Health and Social Services Councils and the Regulation and Quality Improvement Authority would like to thank you for taking the time to complete the questionnaire.

The findings from the questionnaires will be sent to you in due course.

## APPENDIX 3

### “GRAFFITI WALL”

The seminar participants had an opportunity to leave individual comments alongside the collective discussions. A flavour of the contributions is presented here.

- *“Role of advocacy is to work on behalf and with the service user who needs help”.*
- *“There are so many different systems within each home that it’s hard to find one advocacy system that fits all”.*
- *“Advocacy training for all staff, including cleaners”.*
- *“Ensure positive culture promoted, not negative complaint process”.*
- *“Advocacy service must not diminish the Home’s responsibilities and lessen the role of the key worker relationship”.*
- *“Develop audit tool which managers in homes can use to review advocacy within homes”.*
- *“Residents sometimes talk to domiciliary staff before the manager or care staff because they are always very busy and don’t want to be a nuisance”.*
- *“Relative / resident tensions can occur. Advocate is for resident”.*
- *“Advocate needs to be impartial as opposed to independent. Needs to know resident well to act as an advocate”.*
- *“Nurses role is to act as advocate at all times for their patients. Not sure if further developments in terms of independent people need implemented”.*
- *“Advocacy is not understood currently by the very people who need it”.*
- *“Funding will probably be the biggest barrier to providing advocacy”.*

## APPENDIX 4

### CONTACT DETAILS

#### Health and Social Services Councils:

Northern Health & Social Services Council, Houston's Mill Site, 10a Buckna Road, Broughshane Tel: 028 2586 3950 Fax: 028 2586 3951  
Minicom: 028 2586 3950 e-mail: [info@nhssc.n-i.nhs.uk](mailto:info@nhssc.n-i.nhs.uk)  
web: [www.nhssc.org](http://www.nhssc.org)

Southern Health & Social Services Council, Quaker Buildings, High Street, Lurgan BT66 8BB Tel: 028 3834 9900 Fax: 028 3834 9858  
Minicom: 028 3834 6488 e-mail: [reception@shssc.n-i.nhs.uk](mailto:reception@shssc.n-i.nhs.uk)  
web: [www.shsscouncil.net](http://www.shsscouncil.net)

Eastern Health & Social Services Council, 1st Floor, McKelvey House, 25-27 Wellington Place, Belfast BT1 6GQ Tel: 028 9032 1230  
Fax: 028 9032 1750 Minicom: 028 9032 1285  
e-mail: [ecouncil@ehssc.n-i.nhs.uk](mailto:ecouncil@ehssc.n-i.nhs.uk) web: [www.ehssc.org](http://www.ehssc.org)

Western Health & Social Services Council, Hilltop, Tyrone & Fermanagh Hospital, Omagh BT79 0NS Tel: 028 8225 2555  
Fax: 028 8225 2544 Minicom: 028 8224 8389  
e-mail: [info@whssc.n-i.nhs.uk](mailto:info@whssc.n-i.nhs.uk) web: [www.whssc.org](http://www.whssc.org)

Regulation & Quality Improvement Authority  
9th Floor, Riverside Tower, 5 Lanyon Place, Belfast BT1 3BT  
Tel: 028 9051 7500 Fax: 028 9051 7051  
e-mail: [lorraine.wilson@rqia.org.uk](mailto:lorraine.wilson@rqia.org.uk) web: [www.rqia.org.uk](http://www.rqia.org.uk)

Records of focus groups can be accessed via any of the above websites.







Health and Social  
Services Councils  
of Northern Ireland

March 2008

If you would like a copy of this report on disk, in larger print, in Braille, on audio cassette or in another language, please contact your local Health and Social Services Council or the Regulation and Quality Improvement Authority.