



Submissions on the Implementation of the International Convention on Civil and Political Rights

Articles 7, 9 and 10: Older people in Nursing Homes

May 2014

1. Introduction and Overview

Age Action was founded in 1992 and is the largest older person's charity in Ireland. It advocates for people aged 65 and over. Our mission is to achieve fundamental change in the lives of older people by empowering them to live full lives as actively engaged citizens and to promote and protect their rights to comprehensive high quality services according to their changing needs.

At the last census there were 535,393 people aged 65 or over in Ireland, of these 20,802 were resident in nursing homes. Older people are not a homogenous group and face problems in a number of areas. Most of them are well able to make decisions for themselves, but about 9% of people aged over 65 suffer from some form of dementia and may have impaired ability to make decisions. The proportion of people suffering from dementia is much higher in the over 85 age group. Such people may be unable to give consent to admission to nursing homes and hospital, or to give consent to medical treatment including the administration of antipsychotic medication. Those with dementia are especially vulnerable to all forms of elder abuse, with those in nursing homes at particular risk. This submission is largely concerned with the liberty and treatment of older adults who are dependant on others for their care.

The Irish Constitution contains a commitment to liberty in Article 40.4.1¹, as does Article 5 of the European Convention on Human Rights Act 2003. These rights seem to be largely ignored when in relation to older adults.

The Assisted Decision Making (Capacity) Bill 2013 was introduced in order to promote and protect the rights of those who may have difficulties making decisions for themselves as part of the ratification process of the International Convention on the Rights of Persons with Disabilities. These groups include those with mental illness, those with intellectual disabilities, and those suffering from dementia and other neurological disorders. The new legislation does not address the issue of detention/ deprivation of liberty, especially among older people who are admitted to nursing homes, which is of particular concern to Age Action. Our submission concerns Articles 7,9 and 10 of the ICCPR in relation to older adults in residential care institutions such as nursing homes and hospitals.

(a) Dementia

Most people over the age of 65 do not suffer from any impairment of their ability to make decisions, but some do. Dementia is not a normal part of ageing, but it commonly affects older people. The World Health Organisation defines dementia as a syndrome due to a disease of the brain, usually of a chronic and progressive nature, in which there is a disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capability, language and judgement. Consciousness is not impaired. Impairments of cognitive function are

¹ No person shall be deprived of his liberty save in accordance with law

commonly accompanied, occasionally preceded, by deterioration in emotional control, social behaviour and motivation.²

Dementia is most often due to Alzheimer's disease, but cerebrovascular disease is a frequent cause and the two conditions may co-exist in the same individual. Many other illnesses including Parkinson's disease and AIDS may cause dementia. Most forms are irreversible, although some drugs may slow the progress of dementia.

Those in the early stages of dementia can plan for the future, for example by donation of an enduring power of attorney³ which would allow another person to make decisions about financial and some welfare matters when they lack the ability to make these decisions for themselves. They can tell their families of their wishes for their future care.

Older people with dementia face the prospect of deteriorating cognitive abilities which will shorten their lives and make them dependant on others for care. There is considerable stigma attached to dementia, which often results in depression and denial on the part of the older person and their families. As a result it is not uncommon for those with dementia to present to doctors and social workers late in the course of their illness when their decision making abilities are seriously impaired over many areas, and their families are struggling to cope with their physical and psychological needs.

Those in the late stages of dementia lose the ability to speak, swallow and move. They lose the ability to make or communicate most decisions and must have 24 hour care from others.

Family members, often elderly spouses or adult children, may face enormous challenges when caring for older people with dementia at home. The decision to seek admission to a nursing home is not taken lightly and is often seen as deeply stigmatising: they feel they should continue to care for the person at home, and institutional care is viewed as an admission of failure on their part. Acknowledging that they are no longer able to care for an elderly relative or spouse at home is often accompanied by feelings of guilt and sorrow which generate considerable conflict within families. Family members may feel anxiety about the quality and safety of the care offered by institutions.⁴

(b) Concepts of capacity

The ability to make a decision is often referred to as mental capacity. It consists of the ability to receive, understand and weigh information in order to arrive at a decision; and the ability to communicate the decision made. There is a rebuttable presumption of mental capacity. Capacity is assessed in relation to the nature of the particular decision at that particular time. It is known as the

² International classification of diseases (ICD10) World Health Organisation

³ Powers of Attorney Act 1996

⁴ Annual overview report on the regulation of designated centres for older people-2013. Health Information and Quality Authority. May 2014 at p 4

functional test of capacity.⁵ A person may have the capacity to decide that they need to buy a new coat, but lack the capacity to make decisions about investment of their money. The ability to manipulate financial information is often impaired early in the course of dementia.⁶ The inability to make major financial decisions may co exist with the ability to make decisions about medical care or residence.

An older concept of capacity is less nuanced and consists of an all or nothing approach: either the person has full capacity and can make all decisions for themselves or they do not. This global approach to capacity assessment means that an older person may be deemed to have no capacity to make any kind of decision, even if in reality they are perfectly capable of making some decisions. This concept of capacity is retained in the current Wards of Court system.⁷

(c) Legislative background

In Ireland there are currently two main forms of legislation which allow decision making on behalf of those who lack the ability to make decisions:

(i) Enduring Power of Attorney

The person, while they still have the ability, can donate an enduring power of attorney to another person.⁸ In order to be activated, the attorney's powers must be registered when the person loses the ability to make their own decisions. There are two broad areas of decision making: finances and personal care. At present the Act does not confer the power to consent to or refuse medical treatment on behalf of the donor⁹, but does allow the attorney to decide where the person should live, for example a nursing home.

(ii) Wardship

A person who is deemed to be of unsound mind and unable to manage his person or property may become a ward of court. Wardship is governed by the Lunacy Regulations (Ireland) Act 1871. A Committee makes decisions on behalf of the ward who is regarded as lacking any decision making ability and who is essentially stripped of his or her legal rights in that he or she cannot marry, make a will, decide where to live or manage their own affairs.

(d) Assisted Decision making (Capacity) Bill 2013

Ireland now proposes to introduce legislation recognising functional tests of capacity and repealing the Lunacy Regulations.

The legislation will allow a person who feels they may shortly lack capacity or whose capacity is in question to appoint a decision making assistant to help them make decisions, or a co decision

⁵ For example section 3 of the Assisted Decision Making (Capacity) Bill 2013(Ireland) . Section 2 of the Mental Capacity Act 2005 (England and Wales)

⁶ Marson *et al.* Clinical Interview Assessment of Financial Capacity in Older Adults with Mild Cognitive Impairment and Alzheimer's Disease. *Journal of the American Geriatrics Society*. May 2009; 57(5):806-14

⁷ Lunacy Regulations (Ireland) Act 1871

⁸ Powers of Attorney Act 1996, Part II.

⁹ Personal care decisions are described in section 4 of the Powers of Attorney Act 1996

maker. If a person is unable to make major decisions for himself a decision making representative may be appointed by the courts, or the court may make orders directly concerning the person. Informal decision makers have wide powers to make personal care decisions for those who cannot make these decisions for themselves. They are unregulated, and the powers granted to them under the Bill have been extensively criticised by NGOs working with the elderly, the mentally ill and the intellectually disabled. The new legislation will incorporate Enduring Powers of Attorney and extend the power of attorneys to allow them to make decisions regarding medical treatment. Those who have the capacity to do so will be able to make advance care directives regarding their future medical treatment. The legislation contains reference to restraint and deprivation of liberty and it is this part of the legislation which causes Age Action most concern (see 4(c))

(e) Elder abuse

Elder abuse in Ireland is defined as a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, and which causes harm or distress to an older person or which violates their human and civil rights. Elder abuse may be subdivided into the following categories:¹⁰

- (i) Physical abuse which includes hitting, slapping, pushing, kicking, misuse of medication and inappropriate restraint.
- (ii) Psychological abuse which includes the use of threats, humiliation, bullying, intimidation, isolation, swearing and other conduct that result in distress to the older person.
- (iii) Financial abuse which is the unauthorised or improper use of an older person's funds, property or resources. It may include theft, fraud, coercion or misuse of enduring powers of attorney.
- (iv) Sexual abuse which is any sexual act to which an older person has not or could not consent, including talking to the person or touching them in a sexual way.
- (v) Institutional abuse occurs in residential or acute care settings and may involve poor standards of care, rigid routines or inadequate responses to complex needs. It may include (i)-(iv) above and other forms of abuse such as discriminatory abuse or neglect.

¹⁰ Protecting our Future. Report of the Working Group on Elder Abuse. September 2002. Dublin. See www.ncpop.ie/whatiselderabuse

2. Article 7

No one shall be subject to torture or to cruel, inhuman and degrading treatment or punishment

(a) Elder Abuse

Older people cannot usually claim to have been tortured but they may experience cruel, inhuman and degrading treatment both in nursing homes and in the community: In Ireland this may be described as elder abuse. Both men and women are affected and the perpetrators are often family members. In a study of elder abuse in the community in Ireland 2.2% of people aged 65 and over said they had suffered some form of abuse in the previous 12 months. 4% said they had suffered some form of abuse since the age of 65. Women were more likely to suffer abuse than men, and people aged 70 and over experienced double the levels of abuse experienced by those in the 65 - 69 age group. Those in poor physical and mental health were more likely to experience abuse.¹¹ Most elder abuse is perpetrated by family members or acquaintances.

Elder abuse does not stop when an older adult is admitted to a nursing home or other care institution: some perpetrators who are family members or acquaintances may continue to abuse the person after admission. Elder abuse is often undetected and unreported, so abusers could continue their activities even if their access to the person is restricted. Abuse may also be perpetrated by staff in residential care settings.

In a recent study of elder abuse in institutional settings 3.2% of staff reported observing a colleague in an act of physical abuse in the preceding 12 months, most commonly restraining the person beyond what was required, or slapping or hitting the person. 57.6% observed neglectful behaviour by others, most commonly not responding when a resident called for help or not bringing a resident to the toilet when they asked. About 6% of staff reported not changing an older person after an episode of incontinence. 5.6% reported giving a resident too much medication to keep them sedated or quiet. 1.2% had observed financial abuse and 0.2% reported observing sexual abuse.¹² The affront to older people's dignity is particularly marked in instances of repeated psychological abuse and neglect, often centring around intimate bodily functions. Such treatment is degrading for those who are so reliant on others for care. Arguments that people who are cognitively impaired do not suffer any lasting effects from such treatment have not been accepted by the European Court of Human Rights. In *Keenan v United Kingdom* it was held that "there are circumstances where proof of an actual effect on a person may not be a major factor...Treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though the person may not be able, or capable of, pointing to any specific ill effects."¹³

¹¹ Abuse and Neglect of Older People in Ireland. Report on the national study of elder abuse and neglect. 2010. National Centre for the Protection of Older People. University College Dublin. www.ncpop.ie

¹² Older people in residential care settings: results of a national survey of staff-resident interactions and conflicts. NCPOP 2011. see www.ncpop.ie

¹³ *Keenan v United Kingdom* [2001] 33 EHRR 903

In England the superior courts have considered the matter of degrading treatment of those who lack decision making capacity on a number of occasions. In *R (Burke) v General Medical Council* Munby J made an *obiter* comment that: "...treatment is capable of being degrading whether or not it arouses feelings of fear, anguish and inferiority in the victim. It is enough if it is judged by the standards of right thinking bystanders- human rights violations obviously cannot be judged by the standards of the perpetrators- it would be viewed as humiliating and debasing for the victim, showing lack of respect for, or diminishing his human dignity."¹⁴

In *R (On the application of Wilkinson) v Responsible Medical Officer Broadmoor Special Hospital Authority* Hale LJ said more succinctly: "the degradation of an incapacitated patient shames us all even if that person is unable to appreciate it."¹⁵

The misuse of sedative medication is also of concern because it not only violates the older person's dignity and bodily integrity but facilitates further abuse.

(b) The use of antipsychotics

Antipsychotic drugs were originally developed to treat mental illness such as schizophrenia and bipolar disorder. They are also administered to older people with dementia who exhibit challenging behaviour such as shouting and wandering. Critics of their use sometimes refer to them as a "chemical cosh". Antipsychotics may be divided into two main categories: conventional antipsychotics such as haloperidol and chlorpromazine, and atypical antipsychotics such as risperidone, quetiapine and olanzapine. Both categories are known to cause serious health problems for older people with dementia including increased risk of stroke and heart attacks, increased risk of falls and infections, and increased risk of death.¹⁶ Their efficacy in treating dementia is very limited and clinicians are asked to consider the risks and benefits before prescribing, and to prescribe as small a dose as possible for as short a time as possible.¹⁷ Both the Irish Medicines Board¹⁸ and the US Federal Drug Administration¹⁹ have issued warnings about the dangers of antipsychotics for older people with dementia. Only risperidone is licensed to use in the treatment of older people with dementia, but many conventional and atypical antipsychotics are prescribed off label. A recent study in Northern Ireland showed that when older people entered care homes there was a sharp increase in the administration of antipsychotics from 8.8% to 18.6%.²⁰

¹⁴ *R (Burke) v General Medical Council* [2005] QB 424 at para 149

¹⁵ *R (On the Application of Wilkinson) v Responsible Medical Officer Broadmoor Special Hospital Authority* [2001] All ER 294 at 79

¹⁶ Gil SS et al. Antipsychotic drug use and mortality in older adults with dementia. *Annals of Internal Medicine*. 2007 Jun 5th; 146(11) : 775-86

¹⁷ National Health Information and Quality Authority. National quality standards for residential care settings for older people in Ireland. February 2009. P37-38. Standard 21

¹⁸ Irish Medicines Board. Update on the safety of Antipsychotic Medicines. (July 2009)

¹⁹ United States Federal Drug Administration Public Health Advisory. Deaths with Antipsychotics in Elderly Patients with Behavioural Disturbances (April 2005).

www.fda.gov/Drugs/DrugSafety/PublicHealthAdvisories/UCM053171

²⁰ Maguire A et al. Psychotropic Medications and the Transition into Care: A National Data Linkage Study. *Journal of the American Geriatrics Society*. 2013 ;61(2):215-21

Many people in nursing homes with dementia are incapable of giving informed consent to medical treatment and it is unlikely that anyone would consent to the use of drugs with such severe and possibly lethal side effects. The lack of efficacy combined with the adverse effects would confer very little benefit on the patient, yet they continue to be used. Their misuse and overuse in nursing homes have been documented in a number of countries, including Ireland. The use of antipsychotics in elderly patients with dementia who are unable to give informed consent to their use; experience no therapeutic benefit; and are likely to suffer adverse effects, including stroke, heart attacks and death amounts to degrading and inhuman treatment.

(c) Responding to Elder Abuse

There is no Irish legislation defining elder abuse and there is no mandatory reporting of elder abuse in Ireland. Many professional groups such as doctors, nurses and social workers have a contractual and ethical obligation to report suspected elder abuse. Recently the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 made it an offence for prescribed groups of persons and organisations to fail to report suspicions of offences against children and vulnerable adults. The offences include physical and sexual abuse and do not include financial abuse or psychological abuse.

The staff of nursing homes should receive training in elder abuse, but it is clear from HIQA's inspection reports that some do not.²¹ Elder abuse may be reported to special elder abuse senior case workers.

If elder abuse occurs in a nursing home the Health Information Quality Authority (HIQA) should be informed.²² HIQA regulates and inspects nursing homes in Ireland. In their overview of nursing homes for older people HIQA reports 373 reports of episodes of abuse in 195 centres in 2013.

Elder abuse rarely results in the prosecution of perpetrators as it is rarely reported to Gardai. Elder abuse is often perpetrated by people who know the older person and are able to exert considerable control over them, usually because they live with the older person or provide care for them. Older people suffering from physical or mental illness may be unable to report what has happened to them, and if they do they may not be believed. Their complaints may be dismissed as part of the paranoia of dementia. Although the courts may regard the age of the victim as an aggravating factor when sentencing those who have committed crimes against older adults, there are no specific penalties for those who offend against older people as there are in the state of California, for instance.

Summary

Older people with disabilities such as dementia and stroke and who are in residential care settings are particularly vulnerable to abuse which may be seen as cruel inhuman and degrading. There is insufficient legal protection for them as there is no statutory recognition of elder abuse. Guidelines

²¹ Annual Overview Report on the Regulation of Designated Centres for Older People-2013. May 2014. Health Information and Quality Assurance (HIQA) at p 34. See Publications www.hiqa.ie

²² HIQA was created by the Health Act 2007

issued in relation to the use of antipsychotics are regularly flouted and the system of inspecting and regulating nursing homes does not allow review of the conditions of those who are particular risk such as those who are detained without their consent. The use of antipsychotics facilitates the detention of older adults in nursing homes by sedating them to the extent that they may be physically unable to leave or ask to leave: they become docile and compliant and also become more prone to falls and serious illness. The ability to make informed decisions is further impaired by sedation.

3. Article 9.

Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No-one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.

There are over 20,000 people aged 65 and over in residential care settings in Ireland, mostly nursing homes and hospitals. A high proportion suffer from strokes, dementia and other neurological disorders and are unable to consent to admission to residential care, or to medical treatment while in such institutions. They are essentially detained indefinitely, usually until the end of their lives. Staff may exert total and effective control over all aspects of their lives including when and if they can leave to visit relatives; medical care; who can visit them; their dress and diet. Antipsychotics, and other sedating medication may be prescribed to ensure compliance, which violates the right to security of person, since they have little therapeutic value, are often used as a means of restraint, and the person has not or cannot consent to their use. Other means of restraint such as the use of physical restraints for prolonged periods may also violate the right to security of person.

The right to liberty is the foundation on which other rights are based including the right to freedom from cruel inhuman and degrading treatment, and the right to be treated with humanity and with respect for dignity.

(a) Legal basis for detention

(i) Wards and Attorneys

If a person lacks the mental capacity to consent to admission, but nevertheless needs care, consent for admission and medical treatment may be given by the Committee of the Ward if the person is a ward of court. Currently about 2000 people are wards of court in Ireland. Some are older adults who lack decision making capacity; others are younger people or children. The number of Wards admitted to residential care settings for older people are relatively small.

Some older persons who donate an Enduring Power of Attorney, donate a power to make decisions on personal welfare which includes a power to decide where the person resides when they have lost the ability to make a decision for themselves. There is currently no power to consent to, or refuse medical treatment, including the administration of drugs such as antipsychotics.

There is no automatic review of a decision to confine an older person to a nursing home or hospital under either the Lunacy Regulations (Ireland) Act or the Powers of Attorney Act 1996. This is in

contrast with the mechanisms designed to protect the rights of those confined in hospitals under the Mental Health Act 2001. The Mental Health Act 2001 does not allow the detention of the mentally ill (which may include those with severe dementia) in non approved institutions such as nursing homes; they can only be detained in hospitals. Only a very tiny proportion of older adults with dementia are detained under the Mental Health Act 2001 at any time.

(ii) Doctrine of Necessity

The common law doctrine of necessity forms the legal basis for the detention of most older persons in residential care settings. The doctrine of necessity in relation to an adult who was compliant but lacked the capacity to consent to admission was discussed by the European Court of Human Rights in *HL v United Kingdom*²³, often called the *Bournewood* case after the hospital involved. It was held that the common law doctrine of necessity was not sufficiently protective of the right to liberty of a person who lacked the capacity to consent to admission. As a result the UK government had to amend the Mental Capacity Act 2005 in order to protect the rights of those who were deprived of liberty in this manner. The European Court of Human Rights has discussed the deprivation of liberty in the context of nursing homes and hospitals on a number of occasions since 2005 and refined the concept of deprivation of liberty.

In Ireland the doctrine of necessity is invoked to admit and detain in residential care facilities those who need care. Usually no one is lawfully able to consent to admission on the person's behalf (see Wards and Attorneys, above), although next of kin are consulted and may well believe they have consented to admission. The person has no automatic right of appeal or challenge to their detention, and there is no automatic review of their situation, either with a view to release or altering the conditions of their detention. This lack of procedural safeguards, in the view of Age Action, amount to a failure to protect against arbitrary detention and amounts to a deprivation of liberty for some people.

(b) Remedy

A person so detained can turn to the High Court under Article 40.4.2 of the Constitution for release, but the person must have access to legal representation or someone must instruct solicitors on their behalf. Since those detained in nursing homes are not seen as being deprived of their liberty or unlawfully detained, there is no automatic access to legal advice in Ireland. There have been no actions against nursing homes or hospitals by those detained under the doctrine of necessity and no successful actions by those with dementia who allege that they are unlawfully detained in mental hospitals after lapse or revocation of the order confining them.²⁴

Summary

Those admitted under the doctrine of necessity are the very people who are most vulnerable to elder abuse: they suffer from dementia or strokes and may have physical disabilities. In addition they may have difficulties communicating, so they are much less likely to be able to complain about

²³ H.L v United Kingdom 45508/99 (2004) ECHR 471

²⁴ See, for example M.McN and Anor v H.S.E [2009] IEHC 236

their treatment, or refuse treatment, or tell another person about it. This combination of disability and detention makes the violation of their security of person more likely to occur and less likely to be discovered.

(c) Assisted Decision Making (Capacity) Bill 2013

The Assisted Decision Making (Capacity) Bill 2013²⁵ has many features which are welcome and would seem to promote and protect the rights of older people. Although some references are made to the issue of restraint of persons who lack decision making capacity, there is no recognition of the distinction between restraint and deprivation of liberty.

The following features are of concern to Age Action:

- (i) The Bill does not contain a commitment to respect the liberty of those who lack full decision making capacity.
- (ii) The Bill contains no definition of deprivation of liberty.
- (iii) The Bill allows informal decision makers, who have not been appointed by the person or by the courts, to restrain a person who lacks decision making capacity, but they are not accountable to the courts or any other body for their actions. The boundary between restraint and deprivation of liberty is often not clear to those working with older people. A piece of legislation which lacks a definition of deprivation of liberty does not offer clarity. The Public Guardian is mandated to issue guidelines on restraint and other matters for informal decision makers, but the Bill does not say how this can be done in the context of legislation which lacks a definition of deprivation of liberty.
- (iv) The Bill allows others such as attorneys and decision making representatives who are appointed and accountable to restrain the person but not deprive them of liberty, although this is not meaningful if the legislation does not define deprivation of liberty.
- (v) The Bill implies but does not explicitly state that the Circuit Court can authorise deprivation of liberty, but there is no guidance on the criteria that must be met, or the safeguards which should exist to protect those who are deprived of liberty.
- (vi) The Bill only recognises that wards of court may be deprived of liberty and undertakes to review their situations if they are confined to a hospital or nursing home. There is no recognition that many older people in nursing homes, detained under the doctrine of necessity, are also deprived of liberty and that their conditions should be reviewed. As there is no recognition that those detained under the doctrine of necessity may be deprived of liberty, there can be no statutory regime for the review of their detention, or of the conditions of their detention.

If enacted in its present form this legislation will not promote or protect older adults' rights to liberty and security of person.

²⁵ www.oireachtas.ie/bills/2013/8313/b8313d.pdf

It is very difficult to assess the true numbers of older people who are deprived of their liberty under the doctrine of necessity. Significant numbers of people have not or cannot consent to admission to residential care, but not all are deprived of their liberty in that they can leave to visit their families and friends, or go shopping or to church or attend important events, they can receive visitors at any time and can use the telephone or internet when they want to. Some older persons are completely and effectively controlled by the staff of the care institution and do not enjoy even these basic freedoms, and their docility and compliance is ensured by the administration of medication such as antipsychotics: these are the people who can truly be said to be deprived of liberty. Their true numbers are unknown, but may amount to thousands of people.

4. Article 10

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

Most residential care institutions treat their residents with humanity and dignity, but there are exceptions. We have already commented on the widespread use of antipsychotics as a first line treatment for challenging behaviour, and the lack of non-pharmacological behavioural interventions; the use of antipsychotics as a means of restraint; and to ensure compliance in situations of deprivation of liberty. None of these things can be construed as humane actions, nor do they show respect for the dignity of the person. A lack of resources is not an excuse for the violation of the rights of others, particularly very vulnerable people.

Review of reports of closures of eleven nursing homes in a two year period²⁶ for repeated breaches of standards reveal reports of residents not being able to bathe or shower for a month; physical and verbal abuse by staff; failure to provide medical attention in a timely manner; waking residents in the early hours of the morning to give medication; and failure to provide food. Other reports describe failing to respond for calls for help, delaying or refusing to help residents to the toilet or clean them after episodes of incontinence.²⁷

Many of these incidents may be attributed to insufficient staff with insufficient training in Irish nursing homes.

5. Summary

Staff in nursing homes exert considerable power over the people in their care, who are often suffering from cognitive impairment and physical disabilities. They are effectively detained for life in these institutions without review either of the fact of their detention or the conditions under which they are detained. The failure to acknowledge the fact of older people's detention in nursing homes results in a failure to oversee the conditions in which individuals who are deprived of liberty are detained, and allows violations of their rights to flourish. Such violations can be categorised as cruel

²⁶ Eleven Nursing Homes Closed After Inspections. Evelyn Ring. Irish Examiner August 23rd 2012

²⁷ Older people in residential care settings: results of a national survey of staff-resident interactions and conflicts. NCPOP 2011. see www.ncpop.ie

inhuman and degrading treatment (Article 7) and a failure to treat the person with humanity and respect for their inherent dignity (Article 10).

The failure to legislate on the matter of the liberty of older adults in nursing homes in the Assisted Decision Making (Capacity) Bill is a serious omission. It represents a failure to recognise that older persons in nursing homes are the bearers of rights that should be protected and promoted. Legislation to cover this important area should be enacted promptly if Ireland is to honour its obligations under the ICCPR, the Constitution and Article 5 of the European Convention on Human Rights.

We think that an International Convention on the Rights of Older People would enhance the protection of older people's rights in Ireland.