



VERSION 1.0

ADULT SAFEGUARDING PRACTICE GUIDANCE

PEER ABUSE

The National Safeguarding Office
safeguarding.socialcare@hse.ie

PEER ABUSE



All adults have the right to live a life free from abuse and exploitation. The HSE is committed to upholding this right and has endorsed the principle of ‘zero-tolerance’ of abuse wherever it occurs. The **HSE National Safeguarding Policy**, defines zero tolerance as “The requirement that there should be no acceptance of abuse or neglect of any kind”

Any form of abuse is unacceptable and should not be normalised. The focus of the zero tolerance approach is to ensure that all safeguarding concerns raised are considered and assessed appropriately.

WHAT IS PEER ABUSE?

A person wearing a white lab coat is shown from the chest up, with their arms crossed. They are looking out a window with light-colored curtains. The background is bright and slightly blurred, suggesting an indoor setting with natural light.

This is an abusive interaction involving one service user towards another or towards a group of service users within a care setting. It can occur in any communal setting, such as day centre, club, residential care facility, nursing home or other care setting. Bullying can be considered as a manifestation of peer abuse.

Part of the practice role for health and social care staff is to prevent and decrease the likelihood of instances of peer abuse occurring. It is also the responsibility of staff and managers to analyse why such incidents are happening especially if they are prolonged and recurrent.

CONTEXT IN OLDER PERSONS SERVICES

Peer abuse concerns in the day centre, respite care, or nursing home setting are often likely to occur as the result of a conflict situation such as competition for resources (e.g. a preferred television chair in the lounge or control of the TV remote control). Peer abuse can also involve a relatively physically or cognitively unimpaired resident losing patience with their more impaired counterpart or indeed experiencing long- standing disruptive and repetitive behaviours by another resident with, for example, dementia related behavioural issues. Recently published international research provides an overview of peer aggression in older persons in residential settings and concludes that while the incidence can be hard to measure; “several studies... arrive at victimisation prevalence rates around 20% (of nursing home residents)” [2]

CONTEXT IN DISABILITY SERVICES

In the course of their interactions, service users can have negative interactions with one another. Incidents of peer abuse in disability care settings can occur because of a conflict over control of resources, or the ownership of same. They can occur because of relationship difficulties or because of the nature of the intellectual disability of the people involved. They can also occur in the context of a power differential between the person causing concern and the victim of a peer incident.

Raising Peer Safeguarding Concerns

This is a complex area and the individual context of the actual incident and the parties involved is important in considering the appropriate response. There has been debate among health and social care staff as to how to define and classify such incidents and interactions.

In devising this guidance, consideration was given to the position in other jurisdictions where reporting thresholds are in place. Developing guidance material in an Irish context was seen as the best approach rather than the adoption of a threshold approach at this time without a sufficient evidence and research base. In addition safeguarding reports and inspection findings continue to show that vigilance is necessary against the normalisation of a culture of acceptance of abuse. It is therefore vital that staff should be encouraged to question and challenge. Dialogue and on-going engagement with staff/ volunteers is critical to support staff to raise concerns regardless of the outcome.

ASSESSMENT OF PEER SAFEGUARDING CONCERS

The HSE Adult Safeguarding Policy requires that all concerns or incidents raised are assessed in a safeguarding assessment to determine if the concern is deemed a protection from abuse concern.

Safeguarding plans should consider;

- **proportionality**
- **necessity**
- **the will and preference of the service user**

Following assessment it may be concluded that the safeguarding concern is a as non-protection from abuse to be addressed via other appropriate process such as individual care planning, behavioural support programmes, mediation, case mix arrangements etc.

The safeguarding assessment can consider context as well as the nature and impact of the incident to determine if the response is a protection from abuse or a non-protection from abuse response (i.e. a care planning). Staff should always be encouraged to come forward,

question, and raise a concern regardless of the outcome. All incidents and the subsequent actions taken should be recorded, to support active learning and quality improvement. Risk management and analysis is also part of prevention and responding to incidents to reduce likelihood of re-occurrence.



EDUCATION AND PREVENTATIVE MEASURES

Education, support and supervision to assist staff/ volunteers understand and adequately recognise the nature of abuse is most important. Without this it is possible that safeguarding incidents could be minimised or the impact could be ignored.

In considering the potential for abuse of a service user by another service user there is a fundamental need to focus on staff/volunteer education and prevention measures.

These measures include:

- Adequate empowerment of adults to keep themselves safe by support, education and advocacy.
- Programmes to address bullying, sexuality and relationships.
- Raising awareness among professionals on the individual factors likely to lead to abuse.
- Adequate education for staff and volunteers to identify the environmental circumstances in which abuse may occur.
- Adequate education on the prevention, reduction and safe use of restrictive practices.
- A relationship based approach is vital for better safeguarding outcomes based on giving the service user all the supports and communication aids to allow them express their will and preference.
- Developing adequate person-centred behaviour support plans
- Careful consideration of the appropriateness/ suitability of shared living arrangements.
- Skilled and appropriate use of best practice and current risk assessment models and systems.
- Building a culture in the organisation that welcomes; reflective practice, appropriate risk taking, and critical learning.
- Building a relationship of trust with adult service users to facilitate any disclosure of abuse as early as possible.
- Building on existing good inter-agency relationships, and endeavouring to ensure that there is always effective communication with adults and their wider circle of support.

BEST PRACTICE ADVICE

- If a safeguarding concern is raised it is processed as per the requirements of the Adult Safeguarding Policy
- It is important to consider contextual factors such as impact, intent, capacity, power differentials, behaviour support, and living arrangements within services.
- Staff can discuss and seek clarity from line manager and/or Safeguarding Teams at any point, when coming to a decision on whether to raise a concern.
- Staff should always be encouraged to question and critically reflect on their practice. They should always be supported in raising a concern regardless of any potential outcome.
- Advice and guidance can be sought from Safeguarding and Protection Team at any time.

CASE STUDY 1

A RESIDENT ASSAULTED BY OTHER RESIDENTS ON AN ON-GOING BASIS IN A DISABILITY CENTRE

A resident at a disability service was subjected to head grabbing, hair pulling and slapping by two fellow residents on a daily basis over a two year period. The incidents happened especially at meal time and during transport. The actions of the two residents were deemed to be “challenging” and although behaviour support plans were devised (including efforts to separate the residents whenever possible) the incidents continued and over time became normalised.

An unannounced HIQA inspection at the disability service found over 70 incident reports without an outline of safeguarding screenings or effective interventions. Inspectors found evidence that the victim of the abuse had become distressed after having their head and neck repeatedly grabbed by other residents and they concluded that the resident suffered;

consistent peer-to-peer assault on an on-going and repeated basis ...with no consideration of the impact of the behaviours on the victim.

The Inspection noted that the operator of the facility failed to respond and take effective action to protect the resident, whose case notes indicated they were “not at risk” from others. Risk management systems were poor and there was no evidence that the high number of assaults was being escalated to senior management as an urgent issue. In addressing the concerns raised by HIQA the facility developed an action plan which initiated fundamental changes in policy and practice. A proactive education and safeguarding awareness raising programme for staff was commenced, active safeguarding assessment of concerns was introduced and more proactive risk management and escalation approaches were adopted.

CASE STUDY 2

ELDERLY RESIDENT OF A NURSING HOME ASSAULTED BY A FELLOW RESIDENT WITH DEMENTIA

Mary (86) a frail resident of an older persons unit was knocked to the floor by Jim who is also a resident. Jim has significant cognitive impairment due to advanced stage dementia. The incident left Mary physically bruised and sore. She was also shocked, upset and frightened. A safeguarding assessment and incident management review were conducted in a timely and prompt manner. Mary states that she just wants to be safe. She does not want to see Jim moved from the unit and she does not wish to move herself. She does however have a fear and anxiety of Jim. Response options and future prevention were discussed as was the impact on Mary including the risk of a repeat incident.

Mary's daughter is unhappy about the supervision standards in the facility and she makes demands that Jim is medicated/ sedated so he cannot move about unsupervised or else she wants him moved to protect Mary from a re-occurrence. Advice was sought from the Safeguarding Team and the HSE Risk Manager. A safeguarding plan is devised taking into account Mary's perspective. A support and supervision plan was devised for Jim to include clinical review. The incident analysis also identified a need for a review of approaches to dementia care residents generally, especially at key times as well as the education of care staff.

The Unit management reviewed policies and practices in light of the incident. Changes were made in the routines around Jim and other residents. Staff members were also given education on dementia and techniques to reassure Jim and to redirect him when becoming stressed. There were on-going challenges communicating with Mary's daughter who was not happy with the Unit staff however the Director of Nursing continued to communicate with her and offered appropriate reassurance on the steps taken to safeguard Mary.