SAFEGUARDING REVIEW TEAM FINDINGS

This document is strictly confidential and for the use of the intended recipient only

The content of this document is of a sensitive nature and may be upsetting to some readers

Please note there is an existing court order that prohibits the publication of anything which could identify the injured party or the nursing home either directly or indirectly

Introduction and Background

A serious incident took place in a Community Nursing Unit (CNU) in April 2020. A HSE staff member was subsequently arrested and convicted.

Due to the serious nature of this incident the HSE commissioned two investigations:

1. The HSE National Director for Quality Assurance and Verification commissioned the National Independent Review Panel (NIRP) to complete a review within the CNU. The focus of this review was to examine the circumstances of the incident in line with the governance arrangements and to identify learning opportunities. The NIRP review outlines findings and recommendations.

2. The HSE Chief Officer of the area also commissioned a safeguarding review to identify if any further reportable incidents may have occurred and to ensure that any such incidents were dealt with in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy 2014. The Safeguarding Review findings and recommendations are outlined below.

Safeguarding Review

Between October 2020 and November 2021, the Safeguarding Review Team met with residents, families and staff. They also carried out a review of safeguarding and incident reports and resident files. The Safeguarding Review Team sought to ascertain whether there were other reportable incidents under the HSE Safeguarding Vulnerable Person's at Risk of Abuse Policy which might need to be reported to the Gardai and investigated accordingly. The Safeguarding Review Team adopted a zero tolerance approach to the possibility of abuse occurring. If they had reasonable grounds for concern in relation to sexual or physical abuse, then these were notified to the Gardai for appropriate follow-up.

Findings

The Safeguarding Team found reasonable grounds for concern in relation to physical or sexual abuse for 21 residents. These concerns were taken seriously and they have been managed in line with the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy (2014). The safeguarding team did not investigate any of these allegations and reportable incidents as this is outside their remit. They made the appropriate reports and ensured that Safeguarding plans were in place. All of these concerns were notified to the Gardaí.

The Safeguarding Review Team found reasonable grounds for concern in relation to psychological abuse for two residents. Concerns relating to psychological abuse do not meet the criteria for notification to An Garda Síochána. These concerns were managed in line with the Safeguarding Policy 2014 which outlines the necessary steps that should be taken in relation to safeguarding plans.

The Safeguarding Review Team also found reasonable grounds for concern in relation to one other former resident based on missing sections in this resident's file. The full resident's file has subsequently been located. The Safeguarding Review Team reviewed this file in May 2023 and no concerns were identified.

Recommendations

The Safeguarding Team made five recommendations, which are outlined below. This section also includes an update on actions taken in response by the service:

Recommendation 1:
Documentation. The Community Health Organisation should ensure the implementation of all HSE Record Management and Documentation Policies. This should include regular review and auditing of documentation recording in CHO Community Nursing Unit. Fundamental improvement is required to the day to day recording systems to achieve safe healthcare delivery and protect the wellbeing of residents in this Community Nursing Unit. Furthermore, there needs to be clear documentation in relation to safeguarding issues and the decisions made in relation to them. The voices of the residents, and their will and preference should be clearly documented. This recommendation should be brought to the attention of HSE National Community Operations.
Action: • The CNU completed a review of all resident files in 2021 to ensure all documentation was filed in the correct order in the appropriate resident's file • Documentation review and auditing is ongoing • A safeguarding checklist and log has been implemented in the CNU to track decisions and actions related to safeguarding reports. This aims to ensure that the service and staff operate in compliance with the HSE National Policy on Safeguarding Vulnerable Persons at Risk of Abuse (2014) • There is representation from local Older Persons Services on a national working group to develop and implement an electronic healthcare record system for Older Persons CNUs

Recommendation 2:
The Community Health Organisation should request that the HSE National Safeguarding Office review their Safeguarding Training in relation to its subject content. The learning from this review suggests that abuse of older persons should be given greater priority with a specific focus on the recognition and reporting of sexual abuse in older adults. There should also be further development within the Safeguarding training modules on the identification and management of institutional abuse. Any external medical, health or social care professional involved in the care of any resident must have attended safeguarding training. This recommendation should be brought to the attention of HSE National Community Operations.

Action:
• Safeguarding is discussed at daily team briefings, monthly multi-disciplinary team (MDT) meetings, monthly ward management meetings and monthly Quality & Patient Safety (QPS) meetings in the CNU
• Safeguarding is a focused agenda item at the monthly ward management meetings supported by the toolkit for managers training provided by the National HSE Safeguarding Office in 2022
• Safeguarding is discussed at the bi-monthly resident's committee meetings
• A safeguarding checklist and log has been implemented in the CNU to track decisions and actions related to safeguarding reports. This aims to ensure that the service and staff operates in compliance with the HSE National Policy on Safeguarding Vulnerable Persons at Risk of Abuse (2014)
• Safeguarding Training online is mandatory for all HSE staff. Older Persons Services have implemented the following additional safeguarding training for staff:
    ○ In person Safeguarding Training
    ○ Designated Officer Training
    ○ Safeguarding Toolkit for Managers Training
    ○ Promotion of World Elder Abuse Awareness Day as part of the annual programme of events within the CNUs

Recommendation 3:
The Community Health Organisation should ensure that all of the CHO Community Nursing Units have clear supervision structures in place in line with current policies, this supervision process should be extended to all staff working in residential centres. Adherence to current HSE Human resources policies to address poor practice will assist in reducing the likelihood of safeguarding concerns arising. Safeguarding should be an agenda item in the supervision of all staff. This recommendation should be brought to the attention of HSE National Community Operations.
Action: • The CNU has a supervisory structure which operates in line with the HSE/Public Health Sector Guidance Document on Supervision for Health and Social Care Professionals; Improving Performance and Supporting Employees (2015) and the Nursing and Midwifery Planning Development Unit Guidelines (2015)

Recommendation 4:
The Community Health Organisation should communicate with National Community Operations to advise that the learning from this review suggests that the development of Adult Safeguarding legislation and national policy should be progressed and that in the interim the Health Service Executive, An Garda Síochána, HIQA and Tusla, should develop and actively promote interagency collaboration to ensure appropriate and timely sharing of information to protect adults at risk of abuse. The development of a Memorandum of Understanding may be required to facilitate this.
Action: • The Community Healthcare Organisation has communicated accordingly with National Community Operations and the National Safeguarding Office • An interagency Community Healthcare Organisation/ local Safeguarding Committee meets on a quarterly basis with representation from the HSE, An Garda Síochána, Tusla, financial institutions and voluntary agencies

Recommendation 5:
Development of a welcome/induction pack for residents and relatives. This should, along with general information about the running of the home include, clear information about safeguarding protocols. This would indicate how to make a complaint and how to raise safeguarding concerns through the local service, local management, national structures and also the external bodies.
Action: • The induction process is initiated with all new residents and their families, prior to admission • Information relating to local management, services on site, governance structures and an outline of the Safeguarding and Complaints procedure is provided verbally and by way of a printed document • Following admission, a Personal Care Plan meeting is organised with the Resident, family and MDT members (Nurse Management, Medical Officer, Social Worker, Physiotherapist and Occupational Therapist) to work together to develop the resident's personal care plan • Each resident is assigned a nurse to act as a key support worker and advocate, who acts as a point of contact for any residents' concerns • The CNU induction pack was updated in 2021 & 2023

All recommendations have been brought to the attention of HSE National Community Operations.

Conclusions

The Safeguarding Review Team have concerns that there is limited understanding and literature on the prevalence of sexual assault in residential older care settings. The NIRP Review Team stated that sexual offenders can be difficult to identify as each will develop their own individual pattern of offending, which makes it difficult for staff or management to detect a sexual predator in the work environment. Following this incident staff are more aware that sexual abuse can occur in residential older person's services and understand the need for greater vigilance.

The HSE has accepted the findings and recommendations of the two reviews. Based on the learning from these reviews and engagements with residents, their families and staff, additional service improvements have been put in place in the CNU:

- Ongoing training to improve staff awareness of safeguarding and the need to report concerns
- Additional staff training in relation to possible signs of sexual abuse in older persons
- Safeguarding is discussed as an agenda item in all CNU meetings
- Ongoing focus on delivering person-centred care for residents
- A CNU Service Improvement Group was set up with a focus on resident and staff wellbeing
- A Community Healthcare Organisation Older Person's Working Group was established to improve record keeping and management

The Community Healthcare Organisation acknowledges and apologises for the trauma surrounding this serious matter and its impact on residents, their families and staff.