Autonomy and Protection in Self-neglect Work: The Ethical Complexity of Decision-making

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Autonomy and Protection in Self-neglect Work: The Ethical Complexity of Decision-making

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ABSTRACT

Self-neglect, in which an individual does not attend to their hygiene, health or home surroundings, is one of the most challenging aspects of adult social care practice. In England, this is now explicitly placed within the remit of adult safeguarding outcomes, as a result of changes in adult social care law introduced under the Care Act 2014. It has been argued that these changes have thrown into relief the ethical dilemmas arising from tensions between respect for autonomy on the one hand and the exercise of a protective duty of care on the other hand. This paper draws on serious case reviews and safeguarding adult reviews in self-neglect cases, along with findings from adult safeguarding research, to propose that an appropriate balance between these two moral imperatives is not always achieved in self-neglect practice. It considers why autonomy appears to be privileged over other considerations, illustrating the complex interplay between law and ethics that gives autonomy pre-eminence. It then considers how a more nuanced, situated and relational approach to autonomy can enable practitioners to move away from dichotomous interpretations of the moral imperatives present in self-neglect work, and can support more nuanced understandings of the ethics of professional decision-making. Finally, it considers the personal and organisational implications of this enhanced ethical literacy.

KEYWORDS

Self-neglect; autonomy; protection; adult safeguarding; ethical dilemmas; ethical literacy

Introduction

Self-neglect may occur when individuals – wilfully or otherwise – do not attend to their hygiene, health or home surroundings to an extent that poses a danger to their safety or well-being. It takes a range of forms and in England is classified in the Care Act 2014 statutory guidance (DH 2016) as a form of ‘abuse and neglect’. Self-neglect thus falls within the statutory remit of safeguarding, which places a duty on local authorities to investigate where adults with care and support needs are experiencing (or are at risk of) abuse and neglect and as a result of their needs are unable to protect themselves. Yet the challenges experienced by health and social care professionals when working with people who self-neglect are well documented, both in research and in individual case reviews, which are required by the Care Act when an adult who experiences abuse...
or neglect dies or sustains serious injury and there is concern about how agencies worked
together (Galpin 2010; Day, McCarthy, and Leahy-Warren 2012; Braye, Orr, and Preston-
Shoot 2014; Braye, Orr, and Preston-Shoot 2015). The question at the heart of the chal-
lenge, and which is addressed in this paper, is how services can respect individual auton-
omy yet at the same time exercise their duty of protection in the context of significant risks
and refusal to engage. For these purposes, a working view of the term autonomy is used to
denote an individual’s self-determination and personal sovereignty (Ashley 2012), imply-
ing freedom to make one’s own life choices (Harding 2012; Twomey 2015). This
freedom is codified in the European Convention on Human Rights (ECHR) as the right
to liberty (article 5) and the right to private and family life (article 8). Protection is taken
to derive from the state’s common law duty of care towards its citizens, encompassing
the requirement to protect from foreseeable harm and to promote ECHR rights to life
(article 2) and to live free of inhuman and degrading treatment (article 3) (Braye and
Brammer 2012).

Both imperatives are recognised in policy. In England, the statutory guidance accompa-
nying the Care Act 2014 (DH 2016) embeds empowerment (defined as people being
encouraged to make their own decisions, para 4.13) alongside protection as key adult saf-
guarding principles. While the tension between autonomy and protection is not made
explicit, the guidance refers to ‘the importance of balancing safeguarding with empower-
ment’ (para 14.219). That this is difficult to achieve is evidenced in case reviews. For
example, Lawson (2011) has observed that the tension between safety and choice was
central to the difficulties experienced by the multi-disciplinary team involved in a case
under review, while in another case (LGO and PHSO 2014), a focus on independence by
a caring, well-motivated team led them not to consider whether the individual concerned
was able to manage their environment. Determining an individual’s mental capacity to
make an autonomous decision, using the framework set out in the Mental Capacity Act
2005, can be pivotal. The Act provides for a decision to be made by others in the best inter-
est of someone who lacks capacity to make it, but supports their right to make an auton-
omous decision if they have capacity. It is in the latter case that the key difficulty resides. In
a survey about self-neglect work of adult safeguarding practitioners and managers
working for English local authorities, Braye, Orr, and Preston-Shoot (2014) found that
the key challenge most commonly mentioned was working with people considered to
have mental capacity and refusing help or support; it is often found too at the centre of
individual case reviews. Exploring the resolution of this ethical conundrum, namely how
to navigate between principles of autonomy and self-determination on the one hand,
and protection or a duty of care on the other hand, is the focus of this paper.

We draw first on previous research (Braye, Orr, and Preston-Shoot 2015; Preston-Shoot
2016) into reviews of individual cases (previously known as serious case reviews (SCRs) and
now renamed safeguarding adult reviews (SARs) since implementation of the Care Act
2014. A systematic search of all Safeguarding Adult Boards (SAB) websites in England
was undertaken. The analytical method by which themes were derived from these
reviews of the outcomes of practice has been described elsewhere (Braye, Orr, and
Preston-Shoot 2015). In the context of this paper, the focus is on those reviews that
comment on the ethical dilemmas of practice. We add to this evidence from the published
research literature to support our contention that the balance between autonomy and
protection is not always found in practice with self-neglect, and to illustrate the harms
that result. We then explore the question of why autonomy is often found to be privileged, deliberately or unreflectively, over other considerations. Finally, we go on to suggest positive ways forward that might constitute ethical practice in the face of this dilemma and consider the organisational implications of such practice.

Evidence from case reviews

Amongst over 60 individual case reviews that feature self-neglect in England and Scotland (Preston-Shoot 2016), one-third comment on the complexity of balancing autonomy with protection in cases where an adult who self-neglects is deemed to have decision-making capacity. Fifty percent make recommendations designed to improve mental capacity assessments. Forty-three percent refer to skills for trying to engage with people who are hard to reach or who decline assessment and support. Thirty-eight percent emphasise the importance of person-centred practice, namely navigating the complexity of recognising the outcomes desired by the individual but seeking to explore their expressed choices through respectful challenge. Reviews have commonly concluded that adequate consideration was not given to a significant of individuals’ support needs alongside their right to self-determination. For example, a Scottish review (Glasgow APC 2015) concluded that the right to self-determination of a mother with dementia and her son had been allowed to override their right to support and protection, such that an incorrect balance had been struck between these competing rights. Similarly, a SAR (Hampshire SAB 2015) observes that professionals should have questioned whether prioritisation of self-determination was the most beneficial approach to take for a woman with mild learning disability, personality disorder and epilepsy who died following serious but unrecognised health complications. Another (Lambeth SAB 2012), finding that the professionals had assumed that the individual was making decisions with capacity, concluded that the absence of a plan to meet his housing, care and support needs amounted to a failure of a duty of care.

Many case reviews have also found the question of mental capacity, which is key to the individual’s choice about care and support, to be less clear-cut than assumed by those involved. One (Lawson 2011) noted how the presumption of capacity and non-intervention was followed without question, even when the service user was left vulnerable by his decisions. The review concluded that a failure of morale amongst the professionals involved, when faced with disagreements with the service user and his caregiver, led to a failure of will. There was no focus on the person’s capacity to take decisions, no carer’s assessment, and no systematic consideration of risks and legal options. A SCR focusing on the work undertaken with a young man with Down’s syndrome and mental distress concluded that professionals had given ‘misplaced respect’ (Flynn and Eley 2015, 33) to his choices. They failed to assess his decision-making capacity when he refused beneficial interventions, despite the strong likelihood that he did not have a clear understanding of the medium to longer term consequences of doing so. In another (Braye 2016), concerns were expressed that capacity was treated as an attribute applying to all the individual’s decisions rather than to a specific decision as required under section 2 of the Mental Capacity Act 2005, that capacity was not reviewed at all appropriate points, and that medical evidence of possible impaired executive brain function, which would have affected the individual’s ability to use and weigh relevant
information, was not known to the social care practitioner undertaking a capacity assess-
ment and was therefore not considered.

Several SCRs (Brown 2014; Klée 2015) take issue with professionals who justify their
approach (often non-intervention) by reference to an individual’s lifestyle choice, ques-
tioning whether the adults who were self-neglecting in these cases were really weighing
up the relevant information necessary to arrive at an informed decision. A SAR (Sunderland
SAB 2015), focusing on self-neglect involving a mother, son and daughter, considered that
mental capacity was used by agencies to justify not taking action, but that the outcome
was neither empowering nor protective. It observed that lifestyle choice might be a
reasonable general statement about the right to self-determination but that it should
have been challenged robustly, especially as the decision-making capacity of those
involved was doubtful. It concluded that the view that self-determination should take pre-
cedence over all other considerations was seriously flawed and that authority to act was
not used where clearly it should have been. Unexamined presumptions of capacity often
prove to be neither protective nor supportive of individuals’ autonomy (Brown 2014).

Scourfield (2010) makes a similar observation when analysing another SCR (Cornwall
and Isles of Scilly SAB 2009). In that case, practitioners may have assumed that the
adult’s self-neglect was the result of a lifestyle choice without clarifying whether she
herself consciously saw it as a decision she had made. What these reviews recommend
is that practitioners and managers must interrogate what they mean by ‘lifestyle choice’
and in each unique case establish the individual’s own perceptions and attitudes
towards risk, alongside their strengths, resilience and resourcefulness.

Taken together, the case reviews warn of potential dangers: elevating autonomy over
consideration and open discussion of potential for harm; taking mental capacity for
granted despite indications that it should be assessed; and using terms such as ‘lifestyle
choice’ without an adequate exploration of the extent to which such choices are in fact
the clear capacitous wish of the individual. They provide support for more sophisticated
and nuanced approach to autonomy that takes into account the intricacies of choice
and the complexities of mental capacity.

**Evidence from research**

Research papers shed further light on the problems raised by the challenge of balancing
autonomy with protection in adult safeguarding generally and self-neglect more specifi-
cally. Fyson and Kitson (2007, 2010), in studies of practice with people who have learning
disabilities, identify how choice/independence and adult safeguarding developed as par-
allel agendas that have too often failed to connect. Although, since they were writing, the
Care Act 2014 and the Making Safeguarding Personal initiative (Lawson, Lewis, and Williams
2014) have gone some way to providing a framework that can reconcile the two, the
legacy of this separation remains and has allowed poor professional practice and abuse
to flourish. Fyson and Kitson also argue that a prevailing focus on the development of indi-
viduals’ practical skills to support their active participation in their communities has not
been matched by support in developing the social and emotional skills to live indepen-
dently, constituting a failure of a duty of care that exposes them to potentially abusive
relationships. Accordingly, they argue for the position that autonomy must be actively pro-
moted and facilitated, rather than expected to emerge safely by default. Moreover, they
recommend that, to minimise the possibility of abuse, autonomy must be mediated by effective adult protection measures and that practitioners and managers must review the orthodoxy that promotes independence and choice as the only acceptable goals.

Manthorpe et al. (2011) concur that empowerment and protection have been separate discourses, debated on parallel tracks. They argue that, whilst an individual’s wishes and needs should form the starting point for a personalised and responsive intervention, safeguarding should also be at the heart of practice. Ash (2010, 2013) too finds that when the tension between protecting autonomy and promoting well-being is resolved in favour of autonomy, there are times when the outcome can be tantamount to abandonment. She suggests that the concept of self-determination has been oversimplified in social work. In her research into safeguarding referrals for older people, she noted an absence of ‘proactive work with an older person on understanding potential risks or identifying ways to mitigate these’ and that the right to make unwise decisions had become a ‘mantra often repeated’ (Ash 2013, p. 108) rather than a starting point for discussion, questioning and reflection. Where this does not take place, professionals may erroneously assume that the individuals they work with invariably share their own starting assumptions about self-determination. Bergeron (2006), reflecting on practice and case file analysis, points out that people in difficult or risky situations may sometimes expect that professionals will provide direction rather than a mutual problem-solving relationship, their own shame and embarrassment at their self-neglect hindering authentic choice. Where professionals’ emphasis on autonomy prevents them from recognising this perception, they then not only disappoint the person’s hope of ‘rescue’ but miss the opportunity to work with them to develop their problem-solving agency.

Braye, Orr, and Preston-Shoot (2014), researching self-neglect practice, found strong professional commitment to supporting an individual’s autonomy to choose their way of life: ‘The default balance for practitioners overall probably tilted towards autonomy, being prepared to envisage extreme personal deterioration if capacity is present and risks to others are not excessive’ (193). In the study interviews, managers were more oriented towards protection as an expression of the duty of care, possibly as a result of their more overt engagement with organisational responsibilities, but this perspective did not necessarily translate to frontline practice.

Galpin (2010), writing about older people, criticises agencies for not addressing the choices that people are making and argues that protection has become a poor relation to autonomy. She observes that independence and choice as commonly used are ‘nebulous concepts’ (254) and that older people are left more vulnerable as a result of a consumerist agenda. Clark (1998) also comments on the conceptual elasticity of empowerment and argues that practice ethics are too general and imprecise to ensure consistent and dependable judgements. He notes social workers’ strong attachment to autonomy and self-determination and the negative connotations attributed to paternalism, but suggests that protection may also be beneficial and justified in situations where welfare and safety are compromised by serious risk. Likewise, McDermott (2011), from an ethic of care perspective, argues that principle-based ethical theory falls short of capturing the complexity inherent in decision-making in relation to self-neglect and that uncritical over-emphasis on autonomy, or for that matter protection, equates to lack of care. Care, she argues, is as valuable as autonomy, embodying emotional connection and empathy.
Thus, alongside SCRs and SARs, research findings too give cause to question notions of lifestyle choice in relation to self-neglect. Service users’ own explanations of their self-neglect often show the impact of demotivation and negative self-perception rather than of conscious choice: ‘I got it into my head that I’m unimportant, so it doesn’t matter what I look like or what I smell like’; ‘I’m drinking, I’m not washing; I wouldn’t say I’m losing the will to live, that’s a bit strong, but I don’t care, I just don’t care’ (Braye, Orr, and Preston-Shoot 2014, 100). As one practitioner interviewed put it: ‘Respecting lifestyle choice isn’t the problem; it’s where people don’t think they’re worth anything different, or they don’t know what the options are’ (Braye, Orr, and Preston-Shoot 2013, 45).

The privileging of autonomy

The evidence from reviews and research, which warns against orthodoxy followed unquestioningly, should remind practitioners and managers that favoured ways of practising can become traps that prohibit or confine thoughtful practice (Senge, 1990). Too often, they construct a context that influences how obligations, roles and responsibilities are configured and how subsequent conversations with adults who self-neglect are conducted. In similar vein, both Twomey (2015) and Preston-Shoot (2016) observe that the way practitioners approach encounters with service users may close down an exploration of the interface between autonomous choice-making and providing good care. The observation that autonomy has ‘become the “default” principle of applied principlism, the principle to be appealed to when principles conflict’ (Wolpe 1998, 43), while originally made in the context of bioethics, seems to be borne out by these reports of contemporary British social care practice. It is important to explore why this should be the case.

There are strong ethical arguments for autonomy; it occupies an important place within principle-based approaches to ethics, and figures in both deontological and consequentialist perspectives (Lillehammer 2012). Deontologists place emphasis on treating the person as an end, not as a means, a position that implies upholding his or her right to self-determination. Consequentialists are perhaps less wedded to autonomy for its own sake and may in some situations decide against it, yet strong arguments can often be made from a ‘rule consequentialism’ perspective that the individual is best placed to know what is in their best interests and pursue it in their own way, leading to better outcomes overall. Yet this level of consensus raises the question of whether a principle can become too dominant and too taken for granted. Hale (2009), for example, observes that respect for individual autonomy is an essential part of respect for human dignity, but questions whether respect for human dignity does not also impose a duty on society to protect people from degradation. In essence, the point to emphasise here is that any univocal principle, when taken to extreme, potentially becomes dangerous, here elevating the principle of autonomy to such a level that it swamps considerations of care and support. The converse of course is also possible, namely the urge to protect disregarding a person’s self-determination.

Ethics and law can be seen to be in synergy to give autonomy a degree of pre-eminence. Keywood (2003, 358) refers to ‘the law’s recognition of the pre-eminence of autonomy as the appropriate moral foundation for individual agency and responsibility’. The statutory presumption of capacity within the Mental Capacity Act 2005 (MCA) – whereby a person must be assumed to have capacity unless it is established through
capacity assessment) that they do not (s.1(2)) – has powerful ethical as well as legal force (Keywood 2010; Twomey 2015). When linked with the further statutory principle (section 1 (4)) that a person is not to be treated as unable to make a decision merely because they make an unwise decision, it lends considerable support to individual decision-making autonomy. It can render professionals reluctant to question an individual’s capacity and choices even when they can identify problematic elements to the individual’s decision-making. As Day, McCarthy, and Leahy-Warren (2012) identify, if an individual has capacity, practitioners feel they must step back and wait for a crisis. Some research has suggested that the tendency among health professionals is to overestimate capacity rather than to underestimate it (Okai et al. 2007; Lepping 2011). The SCRs and SARs that have inquired into cases of adults who self-neglect are also replete with examples of where decisions have not been respectfully questioned and changes in behaviour have not been explored. As Keywood (2010) notes:

Professionals can and should consider the reasoning abilities of those who benefit from the statutory presumption of capacity. Partly because it does not necessarily respect autonomy to make no inquiry of a person’s decision-making abilities but equally significantly, an approach which does not ask questions of a person’s presumed competent wishes can result in profound self-neglect. (109)

Report authors also acknowledge that, while an unthinking approach to the loosely defined concept of autonomy can lead to neglect of risks, an unthinking emphasis on protection clearly runs the risk of imposing paternalistic professional solutions. Yet by the same token, there comes a point where subordinating the well-being and safety of an individual to the ultimate goal of their ‘autonomy’ may cease to be treating the person as an end in themselves, and result in treating them as a mere means to the end of the principle of that autonomy (Holroyd 2012).

Further legal support for autonomy derives from the ECHR. The Human Rights Act 1998 incorporated Convention rights into domestic British law and requires all public bodies to give effect to those rights when carrying out their work. Article 8 provides a right to respect for private and family life, and article 5 the right to liberty and security of the person. The former is a qualified right, meaning that the rights of the individual must be balanced with the interests of the community or state, and therefore may be limited where warranted, provided interference in these domains is lawful, necessary and proportionate, and in pursuit of a legitimate aim (such as, in the context of self-neglect, protection of ‘health or morals’, or of the ‘rights and freedoms of others’). The latter is a limited right, permitting breach in particular specified circumstances set out in the Convention, such as lawful detention on mental health grounds, in accordance with a procedure prescribed by law. Nonetheless, they provide important support for arguments that privilege liberty and autonomy, and cautionary benchmarks for the interpretation of rights in practice.

How practitioners understand the legal framework within which they work has a powerful influence on professional judgement. Legal rules that are complicated to understand and apply, including those relating to mental capacity and information-sharing, will shape how practitioners perceive their options in cases (Preston-Shoot 2016). Lack of legal literacy and a failure to consider all legal options are common themes emerging from SCRs and SARs (Braye, Orr, and Preston-Shoot 2015). Report authors (for example Lawson 2011, 2015; Brown 2014; Glasgow APC 2015) and researchers (Braye, Orr, and
Preston-Shoot (2014) observe that the MCA is widely misunderstood but is nonetheless used to justify non-intervention. This mirrors the conclusion of the House of Lords Select Committee (2014), a committee of the second chamber of the UK Parliament set up to scrutinise whether the MCA was working as Parliament intended:

The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult. (para. 105)

The committee concluded that legislation should be drafted in clear and simple terms to ensure that powers and duties are clearly understood and implemented.

The decision-specific nature of capacity assessment under the MCA is arguably difficult to apply in the context of self-neglect, which typically results from the interplay between multiple and often relatively mundane acts or omissions that nonetheless have a damaging cumulative effect. One SCR (Brown 2014) makes the point that it is often unclear which specific decisions should be the focus of a formal capacity test, and that practitioners lack clarity about when, in an individual’s gradual slide into self-neglect, the MCA might provide a mandate to intervene. It argues that the Act itself was formulated with single, well-delineated decisions in mind, and that its focus on cognitive processes fails to address the emotional content of decision-making. Equally, it omits explicit consideration of executive capacity, which emerges from the literature (Braye, Orr, and Preston-Shoot 2011; Hildebrand, Taylor, and Bradway 2014) as a significant feature in self-neglect. This refers to the cognitive processes - executive functions – that are controlled by the frontal lobes of the brain. Some executive function impairments cause individuals no difficulty in reasoning through a decision in the abstract, as required in capacity assessments, but leave them unable to judge when they should act on that decision, or to process information in the moment when action is called for. In some cases, this might better account for why self-neglect continues than assuming that it is a result of conscious and deliberate decision-making.

Contemporary political and organisational factors too reinforce the dominance of autonomy, with personalisation a recurrent theme across policy development in adult social care, and choice and control given reinforcement by the statutory assumption (section 1(3)(a), Care Act 2014) that an individual is best placed to judge their own well-being. In reflecting on when interference with choice is justified, practitioners and managers may find little support in a neo-liberal public policy and societal context where the emphasis is on minimal government and on autonomy and individual choice (Galpin 2010). As SCRs (Preston-Shoot 2016) and researchers (Day, McCarthy, and Leahy-Warren 2012) have observed, behaviours such as alcohol abuse may be construed either as a way of life or as evidence of ill-health; the view taken will shape the options that practitioners perceive are available to them to intervene. When agencies are under severe financial pressures, practitioners and managers may divert resources to those who express a willingness to change and away from those believed to be making a lifestyle choice (Cornwall and Isles of Scilly SAB 2009; Torbay SAB 2011). In a related vein, Ash (2013) raises the possibility that the emphasis on individual choice might in practice be
both a way of unconsciously managing dissonance arising from adult safeguarding policy and a device to navigate through high caseloads and resource shortages, by shifting responsibility from services and from the practitioner. Such dynamics are arguably enhanced in self-neglect, where the combination of a service user reluctant to engage and a system overloaded with demands can result in the practitioner taking the service user’s initial ‘no’ for a definitive answer and walking away (Braye, Orr, and Preston-Shoot 2014).

Brown (2014) offers a trenchant critique of the uncritical prioritisation of autonomy, which in one case resulted in professionals relying on an unfounded notion that the person was making free and informed choices when in fact his ability to manage his environment was severely compromised. She warns of the danger of collectively prioritising an illusion of autonomy over pragmatic humane intervention to secure an individual’s well-being, dignity and right to life. Faced with such ethical and legal complexities, practitioners fall back on service user choice and self-determination as a means of managing dissonance arising from ambiguities in public policy and law (Ash 2010, 2013; Day, McCarthy, and Leahy-Warren 2012) with the result that some people are essentially abandoned (Fyson and Kitson 2010).

Towards ethically literate practice

Uncritical adherence to ethical principles can give rise to unsophisticated approaches to practice; it is simplistic to assume that autonomy is good and paternalism is bad, just as it is to assume the opposite. Preston-Shoot’s (2001) review of literature points to how self-determination is problematic as a sole guiding principle for practice. For instance, it assumes that choice is empowering without recognising that decision-making may be profoundly influenced by powerful emotions, such as fear, hopelessness, self-hatred, pride in one’s own independence, or the desire to be accepted. Treating the kinds of decisions that are made in self-neglect work as a dispassionate selection between courses of action does little justice to the feelings or experiences that may be at work and that may affect the person’s views.

More nuanced and less dichotomous interpretations of the moral imperatives for autonomy and protection are needed. Drawing on the evidence explored earlier in this paper, there will be situations in which respect for autonomy must entail questioning how far apparent choice in self-neglectful circumstances is truly chosen, and respectful curiosity (or even challenge) from the practitioner about the thoughts and feelings underlying the individual’s apparent decisions. Equally, protection does not mean denial of an individual’s views, wishes and feelings, or the total removal of all risks to their safety and well-being. And where grounds exist for intervention to be imposed upon an individual, notwithstanding their mental capacity – use of mental health, environmental health or housing legislation are examples here – self-determination may be compromised in the short term in order to preserve the ability to exercise autonomy in the longer-term. As Keinemans and Kanne (2013) identify, moral issues involve a certain level of nuance: ‘the options available are, as it were, fluid, and it is possible to distinguish between two opposing extremes, but there is an infinite number of nuances in between’ (392).

Practitioners are called upon to move away from the technical-rational logic of ‘solving the problem’ of self-neglect and take a more situated, relational approach to deciding
upon the right course of action. More subtle understandings of what autonomy itself involves, taking account of the circumstances, outlook and meaning of autonomy for the individual (McDermott 2011), can help to point the way to effective and ethical approaches. One such understanding potentially comes from the argument that the (neo)-liberal emphasis on independent self-determination is misguided. Rather than consisting simply of non-interference with independent actions by isolated and self-reliant individuals, autonomy in real terms can be seen as existing within relationships that may give direction, support and meaning to one’s decisions. Thus real, meaningful autonomy is relational rather than individualistic (Nedelsky 1989). Though as a feminist Nedelsky recognises the potential for restrictions that relationships may involve, she recognises how valuable they can be also.

There are at least two implications for practitioners here. One is explicit recognition of the relational context in which an individual is situated (Harding 2012; Clough 2014), which, given the complex influences on self-neglect, can include past relationships and life experience. Indeed, sometimes individuals respond more readily to realisation of the impact that their self-neglect is having on others than to the impact that it has on them (Braye, Orr, and Preston-Shoot 2014). Another is that engaging in dialogue with clients on making decisions need not be seen as impinging on their autonomy, but as supporting it (Widdershoven and Abma 2012) – engaging in practice that privileges relationship-building and negotiation, aiming always to preserve the individual’s sense of control. Clark (1998) advises that practitioners should stay alongside clients when decisions are still in the balance and that legal coercion should be avoided where possible, guidance that accords with the evidence-base for positive outcomes in self-neglect (Braye, Orr, and Preston-Shoot 2014). When working with people who self-neglect, it is important to recognise that past experiences, social isolation, or a sense of helplessness and fear may mean that individuals do not see a problem in their circumstances or are unable or unwilling to address them (Day, Leahy-Warren, and McCarthy 2013; Braye, Orr, and Preston-Shoot 2014). Thus, careful assessment is needed of all the factors that limit coping and self-care, including of executive and functional impairment, seeking a means of maximising an individual’s safety while honouring their goals (Hildebrand, Taylor, and Bradway 2014). As Bergeron (2006) notes, a unique intervention informed by the history of how a person has lived and their own perspective on risk and safety does not lose the foundations of their lifestyle choices but expresses healthier versions of them.

Thus ‘concerned curiosity’ (Braye, Orr, and Preston-Shoot 2014) is key to deeper exploration of what autonomy means in any given situation. The statutory presumption of capacity may safeguard liberty but may not promote an individual’s autonomy if their decision-making process is not subject to scrutiny, and practitioners should discover what service users value concerning autonomy (Keywood 2010). Twomey (2015) in similar vein stresses the importance of relationships being taken into an ethical space in which people work together to make sense of what is happening and to find a way forward that will enable the exercise of meaningful autonomy, and Scourfield (2010) suggests that practitioners should talk with people about the outcomes they want to achieve rather than just accept service refusal. Ash (2013) advises discussion of the choices people are making and the risks inherent in their decisions. Her observation that this is not currently a strong feature of practice raises concern about potential violation of the MCA; if the risks inherent in an individual’s situation have not been raised with them,
the practitioner has no way of knowing that the individual has explicitly considered all the information that has a bearing on their decision, which under section 3, MCA 2005, they must be able to understand, retain, use and weigh. It is unclear from SCRs and SARs, which reach similar conclusions about the extent to which risks are explored, whether this omission is because professionals lack confidence in assertive questioning or feel prohibited from challenging people’s apparent choices. Either way, a more comprehensive approach to dialogue is in keeping with a broad view of what may be termed ‘positive autonomy’ (McDermott 2011). As distinct from negative autonomy, which focuses on guaranteeing people’s rights to decide without interference, positive autonomy promotes positive growth that actively helps people to enhance their freedom within their own lives, perhaps close to what Hildebrand, Taylor, and Bradway (2014) call maximising people’s capacity to self-nurture. Flynn (2007) recommends that a life-transforming choice such as refusal of care and support by an individual known to be vulnerable should result in assessment of decision-making capacity and consideration of the factors that prompted the decision, before choice is used as a rationale for setting aside a duty of care. Preston-Shoot (2001) advises that practitioners should maintain contact, explore people’s fears and options, and work with individuals to gain acceptance for less risky decisions, remaining alert to situations where decisions are taken in a context of intimidation and undue influence.

In addition to more nuanced interpretations of autonomy, more nuanced understandings of the ethics of professional decision-making are also needed. Clark (2012) argues that the process of practical reasoning in ethical decisions is inadequately conceptualised: broad principles in ethical codes are valuable but do not provide answers in the localised context of specific cases; nor does the linear logic of decision-making models reflect the realities of practice. He constructs ethical decision-making as a hermeneutic process illuminated by three principles: recognition of the role of personal biography, culture and lived experience; engagement in an iterative process in which all understanding is tentative and provisional; and the importance of mutual dialogue. Counselling against early closure of a decision, he recognises that ‘professionals meantime have to live creatively with the discomfort of no immediately available solution, as well as the discomfort that the time available to find a solution is often strictly limited’ (131).

Banks (2016) proposes the notion of ‘ethics work’, differentiated from textbook ethics by its focus on social workers as moral agents in the context of how they make sense of situations encountered, work out the right course of action, and justify who they are and what they do. Her conceptualisation of the ‘work’ of ethics work – embedded and embodied in the emotions and relationships of everyday practice – resonates strongly with research findings on the components of effective practice in self-neglect (Braye, Orr, and Preston-Shoot 2014).

The focus on relationship, so appropriate in self-neglect work, is pursued too by Weinberg and Campbell (2014), seeing an ethical relationship not as a product but as a process that ‘instead of being impersonal and abstract is highly personal and specific, involving affect, not just cognition’ (43). Weinberg (2010) brings too an additional dimension to the construction of social work ethics, arguing that a view of practitioners as autonomous agents, enacting universal abstract principles, constrains understanding of the wider structural influences and paradoxes within which practice is located, and the taken-for-granted discourses that frame their development. Thus, the notion of ethical dilemma is, she
argues (Weinberg 2014), better replaced by that of ideological dilemma, which (citing Billig et al., 1988) she construes as emanating from the contradictory principles and practices that emerge as discourses in the society or culture as a whole. Such a perspective provides an important recognition that ethical decision-making in self-neglect work is inevitably affected by societal expectations that themselves are complex. For example, Lauder et al. (2005) note two cultural factors—preoccupation with hygiene and sanitation, and tolerance of eccentricity—which together produce an ‘ambivalent and contradictory attitude to those who self-neglect’ (47).

These approaches invite a broader construction of what constitutes ethical practice, a strengthened ethical literacy, which resonates strongly with evidence on the importance of time and relationship in self-neglect work (Braye, Orr, and Preston-Shoot 2014) and with the evidence emerging from SCRs and SARs on failures to engage with the complexity of autonomy in self-neglect.

The personal and organisational implications of ethically literate practice in self-neglect

SCRs and SARs signpost ethically literate practice, even if it is often identified by what did not happen in the cases reviewed. Thus, the relationship that practitioners have with service users should be characterised by concerned curiosity demonstrated through authoritative but respectful questioning. This will explore any rejection of services and the reasoning behind the person’s decisions. But the relationships upon which ethically literate practice in self-neglect depend have implications for the practitioners involved, and for the organisational context in which they work. Practitioners’ narratives (Braye, Orr, and Preston-Shoot 2014) demonstrate that self-neglect work is personally demanding, engaging personal sensibilities and occasionally breaching personal boundaries: ‘You have to give a lot of yourself I think to win the trust of somebody who’s not engaging with any other services’; ‘I think it’s very emotive as well and you’re entering … into someone’s personal life and their world, they don’t want you to go, so it can be a really uncomfortable place’ (135). Some reported helplessness, anxiety, stress, self-questioning and a sometimes intolerable sense of responsibility. Their organisational context posed challenges too, with its expectations of time-limited care-management style approaches, and a norm of case closure in the face of service refusal. Persistent advocacy with managers was often needed to secure the time to engage in the slow-burn work that could result in relationships of trust with service users.

At times practitioners are less exercised by the ethical dilemmas inherent in a specific case than by the frustrations of an organisational environment that denies them the time and space to work in the way they think appropriate. The concept of moral distress is pertinent here. This is differentiated from the notion of ethical dilemma, which is construed as a choice between two courses of action, each of which would compromise an ethical principle (Banks 2012). Moral distress arises ‘when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action’ (Jameton 1984, 6). The practitioner knows what is morally appropriate but is prevented from implementing it (Lynch and Forde 2016; Mänttäri-van der Kuip 2016). As Weinberg (2009) notes, the concept is valuable ‘in tying the personal with the political by recognizing the institutional barriers that hamper practitioners from functioning in ways they would
deem ethical as well as the emotional fall-out from those difficulties’ (2), although she cau-
tions that the paradoxical nature of social work, and the likelihood that ethical trespass
may ensue regardless of what decision is made, mean that no single response is likely
to be entirely morally right.

But organisational adjustments are clearly needed if practitioners are to be able to take
the more nuanced ethical approaches suggested and to engage in processes of moral
reasoning that can encompass the complexities of situation and relationship. Two features
of organisational life emerge from research evidence (Braye, Orr, and Preston-Shoot2014)
as influential on how practitioners are able to work effectively with self-neglect. First are
forums for exploration and dialogue about the ethical dilemmas involved in decision-
making. Supervision has a key role to play here, both in questioning and promoting the
development of ethical positioning, and in supporting the practitioner with the affective
component of their work. Practitioners draw benefit too from opportunities to come
together in practice development discussion and/or to engage with a multiagency
network for exploration of the different ethical perspectives likely to be held on any
given case. As Weinberg and Campbell (2014) note, to secure meaningful engagement
in ethical relationships ‘requires social workers to engage actively in a critically reflective
process, to be vulnerable, to explore instances of ethical trespass, to grapple with contra-
dictions, and to share their insecurities and confusions’ (47).

The second significant organisational feature is workflow: the expectations the organ-
isation has on how cases will routinely progress through predictable stages. The research
found examples of how local authorities had adjusted both team roles and case-proces-
sing timescales to create opportunities for some staff to work in a more time-intensive
way over a longer period of time with some service users, and to engage in the necessary,
unfolding ‘ethics work’ (Banks 2016). Such adjustments can free practitioners to do what
has frequently been referred to as ‘real social work’ (Braye, Orr, and Preston-Shoot2014,
p. 180). Thus, recognition of the organisational implications of ethically literate practice
in self-neglect will better support practitioners with the ethical dilemmas inherent in
the work and mitigate the potential ‘moral distress’ of being unable to implement the out-
comes of more nuanced ethical perspectives.

**Conclusion**

Focusing attention on SCRs and SARs of course has implications for the kind of evidence
that informs this discussion of moral reasoning in self-neglect. Such reviews are carried
out in ‘worst case scenarios’ where fatalities have occurred or narrowly been avoided. It is
therefore to be expected that their findings generally show inadequate attention paid to
protection rather than to autonomy. It must be acknowledged that harms of a different
nature may result from an elevation of protection above autonomy. But the consistent
messages emerging from reviews and research have much to tell us about the potential
adverse consequences of simplifying or idolising autonomy, and the reasons why
practitioners may nevertheless find themselves doing so. What these messages convey is
the need for a sophisticated and reflective approach to understanding, weighing up, and
communicating judgements about autonomy and protection and what they mean in any
given situation of self-neglect, and an approach to ethical decision-making that does
justice to the complexity of the lived experience of both service users and practitioners.
Disclosure statement

No potential conflict of interest was reported by the authors.

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Safeguarding Vulnerable Persons at Risk of Abuse
National Policy & Procedures

Incorporating Services for Elder Abuse and for Persons with a Disability

Social Care Division
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Foreword

With the establishment of the Social Care Division, which provides services for Older Persons and Persons with Disabilities, a consistent approach is required to ensure vulnerable adults are protected from abuse. In that context, there is an opportunity to develop an overarching policy to safeguard and protect clients of Disability Services and Older Persons’ Services from abuse and neglect.

Arising from the Report of the Working Group on Elder Abuse, the HSE established a dedicated Elder Abuse Service in 2007. A National Steering Committee on Elder Abuse was established and local service responses were put in place.

Many disability services have also developed safeguarding policies and practices regarding vulnerable persons.

The work undertaken at national and local level in both Care Groups has highlighted the importance of public awareness and professional expertise regarding abuse of vulnerable persons. This has helped to improve the quality of life for vulnerable persons who may be at risk of abuse.

Building on this expertise and learning, this policy and procedures document now addresses the issue of safeguarding all vulnerable persons across the Social Care Division, encompassing older people and persons with a disability.

This Policy and Procedures will be reviewed within 12 months, taking account of experiences of its use and any relevant developments in legislation and/or other policy initiatives.

Feedback is welcome and should be directed to disability.socialcare@hse.ie or olderpeople.socialcare@hse.ie

Pat Healy,

National Director Social Care
HSE.
Section 1: Policy
The HSE, Social Care Division, for the purposes of this policy and procedures document, considers a Vulnerable Person as an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation.

Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances.
1.0 Introduction

The Health Service Executive (HSE) was established in January 2005 as the single body with statutory responsibility for the management and delivery of health and personal social services in the Republic of Ireland. As outlined in the Health Act, 2004, the objective of the HSE is to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public. Its mission is to enable people to lead healthier and more fulfilled lives.

The Social Care Division supports the ongoing service requirements of older people and persons with disabilities. This is a fundamental step in moving forward with the design and implementation of models of care across both care groups. Social Care services have traditionally been provided by two separate care group structures, services for older people and services for persons with a disability. The common objective of supporting and assisting people to live at home or in their own communities and to promote lifestyle choices provides opportunities for joint working and learning and better outcomes for service users.

In recent decades, society has had to face the reality of abuse of children. The evolving awareness of Elder Abuse, and the complexities arising in responding in a manner which is respectful and empowering is also significant. All service providers must learn from these experiences and put in place overarching supports, policies and procedures aimed at promoting the welfare and preventing the abuse of vulnerable persons.

It is known that older people and persons with disability can become vulnerable to abuse, even in settings which are intended to be places of care, safety and support. This Safeguarding Policy and Procedures builds on and incorporates Responding to Allegations of Elder Abuse: HSE Elder Abuse Policy.

Effective safeguarding requires that services need to be provided through a person centred model of care in a collaborative way with shared responsibility between the service users, their families and carers, health and social care professionals, service organisations and society as a whole.

The Social Care Division is committed to policy and practices which

- promote the welfare of vulnerable persons and
- safeguard vulnerable persons from abuse.

The HSE, Social Care Division, for the purposes of this policy and procedures, considers a Vulnerable Person as an adult who may be restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation.

This may arise as a result of physical or intellectual impairment and risk of abuse may be influenced by both context and individual circumstances. Because of his or her vulnerability, the individual may be in receipt of a care service in his or her own home, in the community or be resident in a residential care home, nursing home or other setting.
There should be a presumption of decision making capacity unless proven otherwise and a person has a right to make decisions which other people may consider as unwise. The autonomy of the individual must be respected as much as possible.

Some people may understand that what is occurring to them is abusive and may weigh the risks and potential consequences of disclosing the abusive behaviour. This can occur, for example, where an older person is subjected to financial abuse by a family member and fears that confronting the issue may fundamentally alter an otherwise valued relationship. Such situations need to be considered carefully, usually at a meeting of key personnel involved with the person. Issues such as severity of risk will need to be considered as well as strategies to empower the person. It may also be advisable to consult with An Garda Síochána.

Safeguarding must be built on empowerment: on listening to the voices of individuals who are at risk, and those who have been harmed.

The development of this overarching policy document for statutory and non-statutory service providers is part of the Social Care Division’s commitment to promoting the welfare of vulnerable persons and safeguarding them from abuse. It seeks to uphold the rights of vulnerable persons to live full and meaningful lives in safe and supportive environments and to ensure the full expression and promotion of people’s rights and responsibilities. This policy provides a framework whereby both statutory and non-statutory service providers can proof their own service specific safeguarding policies and procedures, or develop their own consistent with this policy.

This document is in recognition of the seriousness of the issue and of the responsibilities arising.

The Social Care Division is putting in place service and management arrangements in each HSE Administrative Area to support the implementation of this Policy and Procedure.

Safeguarding is a societal responsibility. Responsibility for safeguarding rests with all service providers and personnel. A dedicated Safeguarding and Protection Team (Vulnerable Persons) will provide support particularly in complex and challenging situations.

**2.0 Policy Statement**

The HSE, Social Care Division, for the purposes of this policy and procedures, considers a Vulnerable Person as an adult who is restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation. This may arise as a result of physical or intellectual impairment and risk of abuse may be influenced by both context and individual circumstances.

The Social Care Division is committed to the safeguarding of vulnerable persons from abuse. It acknowledges that all adults have the right to be safe and to live a life free from abuse. All persons are entitled to this right, regardless of their circumstances. It is the responsibility of all service
providers, statutory and non-statutory, to ensure that, service users are treated with respect and
dignity, have their welfare promoted and receive support in an environment in which every effort is
made to promote welfare and to prevent abuse.

All services must have a publicly declared ‘No Tolerance’ approach to any form of abuse and must
promote a culture which supports this ethos. All policies and procedures must promote welfare,
reflect inclusion and transparency in the provision of services, and promote a culture of
safeguarding.

A core governance responsibility of all services is to ensure that safeguarding policies and
procedures and associated practices are in place and appropriate to the services provided.

3.0 Scope

This Policy and Procedure applies:
- To all statutory and public funded non-statutory service providers (including for-profit
  organisations) with responsibility for the provision of health and social care services to
  vulnerable persons. It applies to all staff and volunteers.
- Across all service settings, including domestic, alternative family placements, residential
care, respite services, day care and independent living (associated support services such as
  transport are also included).
- To all other relevant directly provided HSE services.
- In situations where formal health or social care services are not in place but where concerns
  have been raised by, for example, neighbours, family members and members of the public
  in relation to the safeguarding of an individual and a health and/or social service response is
  required.

The term “disability” for the purposes of this policy applies to persons who have physical,
intellectual or sensory impairments which, in interaction with various barriers, may hinder their full
and effective participation in society on an equal basis with others.1

Any service specific policy documents developed and implemented for the safeguarding of
vulnerable persons must be reviewed against this national HSE policy and must be in compliance
with this policy. It will be the responsibility of each service provider to ensure and demonstrate
compliance.

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1 UN Convention on the Rights of Persons with Disabilities (2006)
4.0 Implementation

Responsibility for leading implementation of this policy and procedure rests with the HSE Social Care Division.

The Head of Social Care in each Community Healthcare Organisation (CHO) will have overall responsibility for implementation of this policy and procedure within their administrative area, and, will ensure that each manager of relevant HSE services and the manager of each relevant HSE funded service will undertake the following:

- Communicate this policy to all staff and volunteers.
- Ensure that service specific procedures are developed, implemented and reviewed in compliance with this national policy.
- Ensure that all adults with a disability and older people in receipt of health and/or social care services and their next of kin / advocates, are informed of local policies / procedures / protocols for safeguarding.

5.0 Regulation

Residential and residential respite centres are prescribed as ‘designated centres’ in the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations, 2013. The Health Information and Quality Authority (HIQA) has, among its functions under law, responsibility to regulate the quality of services provided in designated centres for people with disabilities and older people.

The purpose of regulation in relation to designated centres is to safeguard people with disabilities and older people who are receiving residential services. Regulation provides assurance to stakeholders that people living in designated centres are receiving services and supports that meet the requirements of national standards which are underpinned by regulations.

Regulation has an important role in driving continuous improvement so that people with disabilities and older people have better, safer lives. When a designated centre does not meet the required standards and/or the provider fails to address the specific areas of non-compliance, appropriate enforcement action is taken to either control or limit the nature of the service provided or to cancel a centre’s registration and prevent it from operating.

The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulation 2013 is a significant development in the safeguarding of children and adults who use residential services. These regulations came into operation on November 1st 2013. Within these regulations specific reference is made to protection. Part 2, 8 (1) of the regulations state that “the registered provider shall protect residents from all forms of abuse.” Part 8 – Notification of Incidents 31(1) states that “The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in designated centres: This includes (31 (1) (f)) any allegation, suspected or confirmed, of abuse of any resident.”
The Health Act, 2007 (Care and the Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) Article 6 (1) and (2) sets out the arrangements to be put in place by the registered provider and the person in charge in relation to protecting residents from all forms of abuse, including ensuring that there are policies and procedures in place for the prevention, protection and response to abuse and recording any incidents and taking appropriate action where a resident is harmed or suffers abuse.

Any allegation, suspected or confirmed abuse of any resident in a designated centre in the public, private or voluntary sector must be formally notified to HIQA on the appropriate form (NF06 Form) within 3 working days of the incident being reported.

This National Policy must be used in conjunction with the following as appropriate:

A. *National Standards for Residential Services for Children and Adults with Disabilities*, (Standard 3).

B. *National Quality Standards for Residential Care Settings for Older People in Ireland*, (Standard 8).

C. *HSE Policies for Managing Allegations of Abuse against Staff Members*

D. *HSE National Consent Policy*

E. *Children First: National Guidance for the Protection and Welfare of Children*

F. *Safety Incidence Management Policy*

### 6.0 Definitions of Abuse

Abuse may be defined as “ any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general well being, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms.”

2

This definition excludes self-neglect which is an inability or unwillingness to provide for oneself. However, the HSE acknowledges that people may come into contact with individuals living in conditions of extreme self-neglect. To address this issue the HSE has developed a specific policy to manage such situations – see Section 3.

Although this abuse definition focuses on acts of abuse by individuals, abuse can also arise from inappropriate or inadequacy of care or programmes of care.

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2 Health Information and Quality Authority (HIQA). *The National Standards for Residential Services for Children and Adults with Disabilities*. Dublin, 2013
There are several forms of abuse, any or all of which may be perpetrated as the result of deliberate intent, negligence or lack of insight and ignorance. A person may experience more than one form of abuse at any one time. The following are the main categories/types of abuse.

Types of Abuse

**Physical abuse** includes hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions.

**Sexual abuse** includes rape and sexual assault, or sexual acts to which the vulnerable person has not consented, or could not consent, or into which he or she was compelled to consent.

**Psychological abuse** includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

**Financial or material abuse** includes theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

**Neglect and acts of omission** includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating.

**Discriminatory abuse** includes ageism, racism, sexism, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

**Institutional abuse** may occur within residential care and acute settings including nursing homes, acute hospitals and any other in-patient settings, and may involve poor standards of care, rigid routines and inadequate responses to complex needs. (See Appendix 1).

6.1 Who May Abuse?

Anyone who has contact with a vulnerable person may be abusive, including a member of their family, community or a friend, informal carer, healthcare/social care or other worker.

**Familial Abuse**
Abuse of a vulnerable person by a family member.

**Professional Abuse**
Misuse of power and trust by professionals and a failure to act on suspected abuse, poor care practice or neglect.

**Peer Abuse**
Abuse, for example, of one adult with a disability by another adult with a disability.

**Stranger Abuse**
Abuse by someone unfamiliar to the vulnerable person.
6.2 Where might abuse occur?
Abuse can happen at any time in any setting.

Accidents, incidents and near misses
Lessons can be learned from accidents, incidents and/or near misses. As a result, organisations should have in place a procedure for reporting accidents, incidents and near misses that occur. Accidents, incidents and near misses, particularly those which are recurring, can be indicators of organisational risk, including risk to safeguarding, which needs to be managed. All service providers should have policies in place for incident reporting that are compliant with HSE Safety Incident Management Policy.

6.3 Vulnerable Persons - Special Considerations
Abuse of a vulnerable person may be a single act or repeated over a period of time. It may comprise one form or multiple forms of abuse. The lack of appropriate action can also be a form of abuse. Abuse may occur in a relationship where there is an expectation of trust and can be perpetrated by a person who acts in breach of that trust. Abuse can also be perpetrated by people who have influence over the lives of vulnerable persons, whether they are formal or informal carers or family members or others. It may also occur outside such relationships.

Abuse of vulnerable persons may take somewhat different forms and therefore physical abuse may, for example, include inappropriate restraint or use of medication. Vulnerable persons may also be subject to additional forms of abuse such as financial or material abuse and discriminatory abuse.

It is critical that the rights of vulnerable persons to lead as normal a life as possible is recognised, in particular deprivation of the following rights may constitute abuse:
- Liberty
- Privacy
- Respect and dignity
- Freedom to choose
- Opportunities to fulfil personal aspirations and realise potential in their daily lives
- Opportunity to live safely without fear of abuse in any form
- Respect for possessions

People with disabilities and older people may be particularly vulnerable due to:
- diminished social skills
- dependence on others for personal and intimate care
- capacity to report
- sensory difficulties
- isolation
- power differentials
Adults who become vulnerable have the right:

- To be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs.
- To be given access to knowledge and information in a manner which they can understand in order to help them make informed choices.
- To be provided with information on, and practical help in, keeping themselves safe and protecting themselves from abuse.
- To live safely without fear of violence in any form.
- To have their money, goods and possessions treated with respect and to receive equal protection for themselves and their property through the law.
- To be given guidance and assistance in seeking help as a consequence of abuse.
- To be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will be considered paramount unless it is considered necessary for their own safety or the safety of others to take an alternate course, or if required by law to do so.
- To be supported in bringing a complaint.
- To have alleged, suspected or confirmed cases of abuse investigated promptly and appropriately.
- To receive support, education and counselling following abuse.
- To seek redress through appropriate agencies.

6.4 Non Engagement

Particular challenges arise in situations where concerns exist regarding potential abuse of a vulnerable person and that person does not want to engage or co-operate with interventions. This can be complex particularly in domestic situations. Where an adult indicates that they do not wish to engage or cooperate with the HSE and the HSE continues to have concerns, the HSE will need to consider the issue of capacity and in that regard the following will be noted:

- There is a presumption that all adults have capacity.
- An adult who has capacity has the right not to engage with the HSE or any services, if they so wish.
- If there is a concern that an adult is vulnerable and may or may not have the capacity to make decisions, the HSE may well have obligations towards them.
- The HSE should consider whether the non-cooperation of the individual may be due to issues of capacity, is voluntary or if it could stem from for example some form of coercion.

Decisions as to the appropriate steps to deal with such cases need to be made on a case by case basis and with appropriate professional advice. It is also important to identify the respective functions and contributions of relevant agencies which include An Garda Síochána, Tusla and local authorities. Inter agency collaboration is particularly important in these situations.
7.0 Building Blocks for Safeguarding and Promoting Welfare

7.1 Prevention
While research on what works to prevent abuse in practice has, to date, focused primarily on children, people with intellectual disabilities, older persons and institutional settings, the Commission for Social Care Inspection (CSCI) identified some of the following building blocks for prevention and early intervention:

- People being informed of their rights to be free from abuse and supported to exercise these rights, including access to advocacy;
- A well trained workforce operating in a culture of zero tolerance to abuse;
- A sound framework for confidentiality and information sharing across service providers;
- Needs and risk assessments to inform people’s choices;
- A range of options for support to keep people safe from abuse tailored to people’s individual needs;
- Services that prioritise both safeguarding and independence.
- Multi-disciplinary team work, interagency co-operation and information sharing.

7.2 Risk Management
- The assessment and management of risk should promote independence, real choices and social inclusion of vulnerable adults.
- Risks change as circumstances change.
- Risk can be minimised but not eliminated.
- Identification of risk carries a duty to manage the identified risk.
- Involvement with vulnerable persons, their families, advocates and practitioners from a range of services and organisations helps to improve the quality of risk assessments and decision making.
- Defensible decisions are those based on clear reasoning.
- Risk-taking can involve everybody working together to achieve desired outcomes.
- Confidentiality is a right, but not an absolute right, and it may be breached in exceptional circumstances when people are deemed to be at risk of harm or it is in the greater public interest.
- The standards of practice expected of staff must be made clear by their team manager/supervisor.
- Sensitivity should be shown to the experience of people affected by any risks that have been taken and where an event has occurred.

Each organisation must have an effective procedure for assessing and managing risks with regard to safeguarding. In assessing and managing risks, the aim is to minimise the likelihood of risk or its potential impacts while respecting an ambition that the individual is entitled to live a normalised

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3 Prevention in adult safeguarding, Social Care Institute for Excellence, UK May 2011
4 Volunteer Now - Safeguarding Vulnerable Adults: A Shared Responsibility (2010)
life to the fullest extent possible. In safeguarding terms, the aim of risk assessment and management is to prevent abuse occurring, to reduce the likelihood of it occurring and to minimise the impacts of abuse by responding effectively if it does occur. An organisation should evaluate and put in place risk-reducing measures in respect of all relevant activities and programmes.

No endeavour, activity or interaction is entirely risk-free and, even with good planning, it may not be possible to completely eliminate risks. Risk assessment and management practice is essential to reduce the likelihood and impact of identified risks. In some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual values and freely chooses. In such circumstances, risk-taking can be considered to be a positive action. Consequently, as well as considering the dangers associated with risk, the potential benefits of risk-taking have to be considered. In such circumstances strategies to manage/mitigate the risk need to be put in place on a case by case basis.

A consistent theme in the literature is the value of identifying factors that indicate an increased risk of abuse among adults in the interests of prevention. Identifying risk factors can help to prevent abuse by raising awareness among staff and service managers of the people in their care/support who may be most at risk of abuse. Staff can use these insights to develop effective risk assessments and prevention strategies.

Common personal risk factors include:
- diminished social skills / judgement
- diminished capacity
- physical dependence
- need for help with personal hygiene and intimate body care
- lack of knowledge about how to defend against abuse.

Common organisational risk factors include:
- low staffing levels
- high staff turnover
- lack of policy awareness
- isolated services
- a neglected physical environment
- weak / inappropriate management
- staff competencies not matched to service requirements
- staff not supported by training/ongoing professional development.

7.3 Principles
Vulnerable persons have a right to be protected against abuse and to have any concerns regarding abusive experiences addressed. They have a right to be treated with respect and to feel safe.

The following principles are critical to the safeguarding of vulnerable persons from abuse:
- Human Rights
- Person Centeredness
• Advocacy
• Confidentiality
• Empowerment
• Collaboration

7.3.1 Human Rights

All persons have a fundamental right to dignity and respect. Basic human rights, including rights to participation in society, are enshrined in the Constitution and the laws of the State.

The National Standards for Residential Services for Children and Adults with Disabilities (HIQA 2013 – Standard 1.4.2) requires service providers to ensure that:

“People are facilitated and encouraged to integrate into their communities. The centre is proactive in identifying and facilitating initiatives for participation in the wider community, developing friendships and involvement in local social, educational and professional networks.”

In addition the National Quality Standards for Residential Care Settings for Older People in Ireland (HIQA 2009 – Standard 18: Routines and Expectations) states that:

“Each resident has a lifestyle in the residential care setting that is consistent with his/her previous routines, expectations and preferences, and satisfies his/her social, cultural, language, religious and recreational interests and needs.”

Historically, vulnerable persons may have been isolated from their communities and professional personnel played a major role in their support network. As a result, vulnerable persons may have limited sources of outside assistance, support or advocacy to safeguard them from abuse and to support them if they are ever victimised. It is crucial to provide opportunities for individuals that will expand their relationships and promote community inclusion.

Both services and individuals benefit from having contact with a wide range of people in the community. Reducing isolation through links with the community can mean that there are more people who can be alert to the possibility of abuse as well as providing links with potential sources of support.

It is important to include vulnerable persons in community life as neighbours, co-workers, volunteers and friends. This requires a shift in thinking away from a service user perspective and towards a citizen perspective. Service isolation can lead to unacceptable practices that can become normalised and staff may be cut off from new ideas and information about best practice. It is important that services have strong links with the wider community, especially with regard to preventing isolation and abuse in residential settings and also in the provision of support in the community where both a family carer and the person using the service can become isolated.
7.3.2 Person Centeredness

Person Centeredness is the principle which places the person as an individual at the heart and centre of any exchange concerning the provision or delivery of a service. It is a dynamic approach that places the person in the centre. The focus is on his /her choices, goals, dreams, ambitions and potential with the service seen as supporting and enabling the realisation of the person’s goals rather than a person fitting into what the services or system can offer. This approach highlights the importance of partnerships and recognises the need for continuous review and redevelopment of plans to ensure that they remain reflective of the person’s current needs and that they do not become static. Care planning is a foundation for all effective services and the means to realising the principle of person centeredness. It needs to include the person, their family, the key worker and the staff who provide care.

7.3.3 Culture

“Culture manifests what is important, valued and accepted in an organisation. It is not easily changed nor is it susceptible to change merely by a pronouncement, command or the declaration of a new vision. At its most basic it can be reduced to the observation the way things are done around here”.5

Key to the successful safeguarding of vulnerable persons is an open culture with a genuinely person-centred approach to care/support, underpinned by a zero-tolerance policy towards abuse and neglect. It is important that service providers create and nurture an open culture where people can feel safe to raise concerns. The importance of good leadership and modelling of good practice is essential in determining the culture of services.

All services must have in place a safeguarding policy statement outlining their intention and commitment to keep vulnerable persons safe from abuse while in the care of their services. The statement should be simple and reflect the nature and activities of the organisation.

Human Resource policies are fundamental to ensuring that staff are aware of the standards of care expected of them and support their protection from situations which may render them vulnerable to unsubstantiated/inappropriate allegations of abuse. All service providers must ensure that there are procedures in place for the effective recruitment, vetting induction, management, support, supervision and training of all staff and volunteers that provide services to, or have direct contact with, vulnerable persons.

In addition to the safeguarding policy and associated procedures, each service provider must have in place a comprehensive framework of organisational policies and procedures that ensures good practice and a high standard of service. The following are some of the policy areas that assist in the safeguarding of service users from abuse:

- Recruitment/Induction/Supervision/Training.
- Intimate and Personal Care.
- Safe Administration of Medication.

5 Office of the Ombudsman, Complaints and Complaint Handling,
• Management of service users money/property.
• Behavioural Management.
• Control and Restraint.
• Working alone.
• Complaints.
• Incident Reporting.
• Confidentiality.
• Bullying and Harassment.
• Personal Development to include friendships and relationships, etc.

7.3.4 Advocacy

Advocacy assumes an important role in enabling people to know their rights and voice their concerns. The role of an advocate is to ensure that individuals have access to all the relevant and accurate information to allow them to be able to make informed choices.

Vulnerable persons can be marginalised in terms of health, housing, employment and social participation. Advocacy is one of the ways of supporting and protecting vulnerable persons. Advocacy services may be preventative in that they can enable vulnerable persons to express themselves in potentially, or actually, abusive situations.

The purpose of advocacy is to:

• Enable people to seek and receive information, explore and understand their options, make their wishes and views known to others and make decisions for themselves.
• Support people to represent their own views, wishes and interests, especially when they find it difficult to express them.
• Ensure that people’s rights are respected by others.
• Ensure that people’s needs and wishes are given due consideration and acted upon.
• Enable people to be involved in decisions that would otherwise be made for them by others.

The National Standards for Residential Services for Children and Adults with Disabilities (HIQA Jan 2013) requires:

• “Each person has access to an advocate to facilitate communication and information sharing;” and
• “Each person is facilitated to access citizens information, advocacy services or an advocate of their choice when making decisions, in accordance with their wishes;”

The National Quality Standards for Residential Care Settings for Older People (HIQA 2009) requires:

• “Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making”.

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6 Citizens Information, National Advocacy Service for People with Disability 2010
Access to independent and accurate information improves equality of opportunity and provides a pathway to social and other services. Advocacy needs to respond to a range of complexity, from situations that require limited involvement and intervention, to a level of complexity that requires significant intervention.

There are many types of advocacy that can help to support vulnerable persons which should be considered by service providers:

- **Informal advocacy** – this form of advocacy is most often provided by family/friends.
- **Self advocacy** – an individual who speaks up for him/herself or is supported to speak up for him/herself.
- **Independent representative advocacy** – a trained advocate who provides advocacy support on a one-to-one basis to empower the individual to express his/her views, wishes and interests.
- **Citizen advocacy** – a volunteer is trained to provide one-to-one ongoing advocacy support.
- **Peer advocacy** – provided by someone who is using the same service, or who has used a service in the past, to support another person to assert his/her views/choices.
- **Legal advocacy** – representation by a legally trained professional.
- **Group advocacy** – a group of people collectively advocate on issues that are important to the group.
- **Professional Advocacy** – it is the responsibility of professional staff to advocate on behalf of service users who are unable to advocate for themselves.
- **Public policy advocacy** – advocates who lobby Government or agencies about legislation/policy.

Group advocacy is an important form of advocacy that has the potential to move self-advocacy to a higher level and it should be encouraged, supported and developed by service providers. It provides an opportunity for individuals to speak up on issues collectively and gives them a greater level of confidence to attain their full potential. The importance of ensuring that there is an adequate level of support cannot be over-emphasised.

While families and service providers can be great supporters and often are informal advocates, it may be necessary to have access to independent advocacy. This may be due to the potential for conflict/disagreement among family members and/or service providers and the vulnerable person.

The Health Act 2007 (Care and Welfare of residents in Designated Centres for Older people) Regulations, 2013 state that “A registered provider shall, in so far as is reasonably practical, ensure that a resident ...has access to independent advocacy services”.

**7.3.5 Confidentiality**

All vulnerable persons must be secure in the knowledge that all information about them is managed appropriately and that there is a clear understanding of confidentiality among all service personnel. This must be consistent with the HSE Record Management Policy.
The effective safeguarding of a vulnerable person often depends on the willingness of the staff in statutory and voluntary organisations involved with vulnerable persons to share and exchange relevant information. It is, therefore, critical that there is a clear understanding of professional and legal responsibilities with regard to confidentiality and the exchange of information.

All information regarding concerns or allegations of abuse or assessments of abuse of a vulnerable person should be shared, on ‘a need to know’ basis in the interests of the vulnerable person, with the relevant statutory authorities and relevant professionals.

No undertakings regarding secrecy can be given. Those working with vulnerable persons should make this clear to all parties involved. However, it is important to respect the wishes of the vulnerable person as much as is reasonably practical.

Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. They are not intended to limit or prevent the exchange of information between professional staff with a responsibility for ensuring the protection and welfare of vulnerable persons. It is possible to share confidential information with the appropriate authorities without breaching data protection laws. Regard should be had for the provisions of the Data Protection Acts when confidential information is to be shared. If in doubt legal advice should be obtained.

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 came into force on 1st August, 2012. It is an offence to withhold information on certain offences against children and vulnerable persons from An Garda Síochána.

The main purpose of the Act is to create a criminal offence of withholding information relating to the commission of a serious offence, including a sexual offence, against a person who is under 18 years or an otherwise vulnerable person, with the aim of ensuring more effective protection of children and other vulnerable persons from serious crime. An offence is committed when a person who knows, or believes, that one or more offences has been committed by another person against a child or vulnerable person and the person has information which they know or believe might be of material assistance in securing apprehension, prosecution or conviction of that other person for that offence, and fails without reasonable excuse to disclose that information as soon as it is practicable to do so to a member of An Garda Síochána. The offence applies to a person acquiring information after the passing of the Act on 18th July, 2012 and it does not apply to the victim. The offence exists even if the information is about an offence which took place prior the Act being enacted and even if the child or vulnerable person is no longer a child or vulnerable person.

7.3.6 Empowerment
This principle recognises the right of all persons to lead as independent a life as possible. Every possible support should be provided in order to realise that right. Self directedness recognises the right of the individual to self-determination insofar as is possible, even if this entails some degree of risk. Abiding by this principle means ensuring that risks are recognised, understood and minimised as far as possible, while supporting the person to pursue their goals and preferences.
Future Health: A Strategic Framework for the Reform of the Health Service 2012 -2015 places a focus on a shift towards service provision in the community and a move towards mainstream services rather than segregated services. The Social Care Division of the Health Service Directorate is committed to promoting a culture of trust, respect, dignity, honest communication and positive risk management for all who receive and provide supports.

Effective prevention in safeguarding is not about over-protective paternalism or risk-averse practice. Instead, the prevention of abuse should occur in the context of person-centred support and personalisation, with individuals empowered to make choices and supported to manage risks.

7.3.7 Collaboration
Interagency collaboration is an essential component to successful safeguarding. It can be undermined by single service focus, poor information sharing, limited understanding of roles, different organisational priorities and poor involvement of key service providers in adult safeguarding meetings.

A number of key features have been identified to promote good interagency collaboration such as:

- Leadership commitment to collaboration
- Team working on a multidisciplinary level
- A history of joint working/joint protocols
- Development of information sharing processes
- Perceptions of good will and positive relationships
- Mutual understanding and shared acknowledgement of the importance of adult protection.

It is imperative that all service providers develop, support and promote interagency collaboration as a key component of adult safeguarding.

8.0 Key Considerations in Recognising Abuse

8.1 Recognising Abuse
Abuse can be difficult to identify and may present in many forms. No one indicator should be seen as conclusive in itself of abuse. It may indicate conditions other than abuse. All signs and symptoms must be examined in the context of the person’s situation and family circumstances.

8.2 Early Detection
All service providers need to be aware of circumstances that may leave a vulnerable person open to abuse and must be able to recognise the possible early signs of abuse. They need to be alert to the demeanour and behaviour of adults who may become vulnerable and to the changes that may indicate that something is wrong.
It must not be assumed that an adult with a disability or an older adult is necessarily vulnerable; however it is important to identify the added risk factors that may increase vulnerability. People with disabilities and some older people may be in environments or circumstances in which they require safeguards to be in place to mitigate against vulnerability which may arise. As vulnerability increases responsibility to recognise and respond to this increases.

8.3 Barriers for Vulnerable Persons Disclosing Abuse

Barriers to disclosure may occur due to some of the following:
- Fear on the part of the service user of having to leave their home or service as a result of disclosing abuse.
- A lack of awareness that what they are experiencing is abuse.
- A lack of clarity as to whom they should talk.
- Lack of capacity to understand and report the incident.
- Fear of an alleged abuser.
- Ambivalence regarding a person who may be abusive.
- Limited verbal and other communication skills.
- Fear of upsetting relationships.
- Shame and/or embarrassment.

All staff employed in publicly funded services should be aware that safeguarding vulnerable persons is an essential part of their duty. Staff must be alert to the fact that abuse can occur in a range of settings and, therefore, must make themselves aware of the signs of abuse and the appropriate procedures to report such concerns or allegations of abuse.

8.4 Considering the Possibility

The possibility of abuse should be considered if a vulnerable person appears to have suffered a suspicious injury for which no reasonable explanation can be offered. It should also be considered if the vulnerable person seems distressed without obvious reason or displays persistent or new behavioural difficulties. The possibility of abuse should also be considered if the vulnerable person displays unusual or fearful responses to carers. A pattern of ongoing neglect should also be considered even when there are short periods of improvement. Financial abuse can be manifested in a number of ways, for example, in unexplained shortages of money or unusual financial behaviour.

A person may form an opinion or may directly observe an incident. A vulnerable person, relative or friend may disclose an incident. An allegation of abuse may be reported anonymously or come to attention through a complaints process.

8.5 Capacity

All persons should be supported to act according to their own wishes. Only in exceptional circumstances (and these should be communicated to the service user/resident when they occur)
should decisions and actions be taken that conflict with a person’s wishes, for example to meet a legal responsibility to report or to prevent immediate and significant harm. As far as possible, people should be supported to communicate their concerns to relevant agencies.

A key challenge arises in relation to work with vulnerable persons regarding capacity and consent. It is necessary to consider if a vulnerable person gave meaningful consent to an act, relationship or situation which is being considered as possibly representing abuse. While no assumptions must be made regarding lack of capacity, it is clear that abuse occurs when the vulnerable person does not or is unable to consent to an activity or other barriers to consent exist, for example, where the person may be experiencing intimidation or coercion. For a valid consent to be given, consent must be full, free and informed.

It is important that a vulnerable person is supported in making his/her own decisions about how he/she wishes to deal with concerns or complaints. The vulnerable person should be assured that his/her wishes concerning a complaint will only be overridden if it is considered essential for his/her own safety or the safety of others or arising from legal responsibilities.

In normal circumstances, observing the principle of confidentiality will mean that information is only communicated to others with the consent of the person involved. However, all vulnerable persons and, where appropriate, their carers or representatives, need to be made aware that the operation of safeguarding procedures will, on occasion, require the sharing of information with relevant professionals and statutory agencies in order to protect a vulnerable person or others.

8.6 Complaints

Things can go wrong and do go wrong in any service organisation. People may instinctively regard complaints as a comment on personal performance. However, the appropriate handling of complaints is an integral part of good governance and risk management. The first step for any organisation is to ensure that proper and effective complaint handling procedures are in place.

The office of the Ombudsman suggests that good complaints handling procedures should be well publicised, easy to access, simple to understand, quick, confidential, sensitive to the needs of the complainant and those complained against, effective, provide suitable remedies and be properly resourced.

In January 2007, a new statutory complaints system for the HSE (Your Service Your Say) came into effect. This system allows anyone receiving public health or personal social services to make a complaint about the actions or failures of the HSE. The complaints system also covers service providers with HSE contracts who provide health or personal social services on behalf of the HSE. Part 9 of the Health Act, 2004, outlines the legislative requirements to be met by the HSE and relevant service providers in the management of complaints.

All service providers (statutory and non statutory) must be compliant with “Your Service, Your Say” - The Policy and Procedures for the Management of Consumer Feedback to include Comments, Compliments and Complaints in the HSE.
Complaints procedures provide an opportunity to put things right for service users and their families. They also are a useful additional means of monitoring the quality of service provision. Complaints are best dealt with through local resolution where the emphasis should be on achieving quick and effective resolutions to the satisfaction of all concerned. Vulnerable persons may need particular support to use a complaints procedure.

Constructive comments and suggestions also provide a helpful insight into existing problems and offer new ideas which can be used to improve services and provide an opportunity to establish a positive relationship with the complainant and to develop an understanding of their needs. Complaints should be dealt with in a positive manner, lessons should be learned and changes made to systems or procedures where this is considered necessary. Complaint handling systems should be strongly supported by management and reviewed and adjusted where necessary on a regular basis.

Particular attention should be paid to complaints which are suggestive of abusive or neglectful practices or which indicate a degree of vulnerability.

All cases of alleged or suspected abuse must be taken seriously. All staff must inform their line managers immediately. All services must have effective mechanisms in place to ensure a prompt response to concerns and complaints. Ensuring the safety and well-being of the vulnerable person is the priority consideration (See Section 2).

8.7 Anonymous and Historical Complaints

All concerns or allegations of abuse must be assessed, regardless of the source or date of occurrence.

The quality and nature of information available in anonymous referrals may impact on the capacity to assess and respond appropriately. Critical issues for consideration include:

- The significance/seriousness of the concern/complaint.
- The potential to obtain independent information.
- Potential for ongoing risk.

In relation to historical complaints the welfare and wishes of the person and the potential for ongoing risk will guide the intervention.

Any person who is identified in any complaint, whether historic or current, made anonymously or otherwise, has a right to be made aware of the information received.
Section 2: Procedures
9.0 Responding to Concerns or allegations of Abuse of Vulnerable People

9.1 Introduction

All services must have the capacity/capability to implement policy/procedure and safeguard vulnerable persons.

Some services may have the interdisciplinary personnel directly employed which will ensure this capacity. Other organisations, for example because of their size, may not have this capacity or capability within their organisation and will therefore need to make appropriate arrangements to ensure that they can meet all of their responsibilities in relation to safeguarding vulnerable persons.

The specific provisions agreed with each agency will be identified in the relevant Service Level/Contractual Arrangements.

This procedure applies to all HSE services personnel and to service providers in receipt of HSE funding.

It is the duty of all services, service managers and staff to be familiar with this policy and procedures. Service specific arrangements must be consistent with this policy and procedures.

In each Community Healthcare Organisation, a Safeguarding and Protection Team (Vulnerable Persons) will be available to work closely with all relevant service providers to support the implementation of the response to concerns and complaints of abuse of vulnerable persons in HSE and HSE funded services.

The Safeguarding and Protection Team (Vulnerable Persons) will work in partnership with all relevant service providers to ensure that concerns and complaints are addressed. It will continue to be the responsibility of all staff and services to take action to ensure the protection and welfare of vulnerable people.

The Safeguarding and Protection Team (Vulnerable Persons) will advise and support front line personnel and services and may directly manage particularly complex concerns and complaints.

Neighbours, family members and members of the public can become concerned about the possibility that vulnerable persons may be experiencing abuse in situations where the vulnerable person is not connected to any particular service. In these circumstances neighbours or any other person having a concern should discuss the reasons for their concern with appropriate professionals such as Public Health Nurses and GPs who will be in a position to provide assistance in ensuring that the concerns are responded to including engagement with the Safeguarding and Protection Team.
9.2 Organisational Arrangements to Support Procedural Objectives

Community Healthcare Organisation Safeguarding and Protection Team (Vulnerable Persons)

The Safeguarding and Protection Team will be available to:

- Provide an advice service to any person who may wish to report a concern or complaint of alleged abuse of a vulnerable person.
- Receive reports of alleged abuse of vulnerable persons on behalf of the HSE.
- Support and advise services in responding to reports of alleged abuse.
- Assess and manage complex cases of alleged abuse.
- Provide training to staff.
- Maintain information/records. Collect and collate data in a consistent format.
- Participate in assurance processes.

Designated Officer

Each service (HSE and funded) providing services to people within the service who may be vulnerable will appoint a Designated Officer who will be responsible for:

- Receiving concerns or allegations of abuse regarding vulnerable persons.
- Ensuring the appropriate manager is informed and collaboratively ensuring necessary actions are identified and implemented.
- Ensuring reporting obligations are met.
- Other responsibilities, such as conducting preliminary assessments and further investigations, may be assigned within a specific service.

The Designated Officer will usually be a relevant professional or work in a supervisory/management role.

All concerns/reports of abuse must be immediately notified to the Designated Officer and in the event of their unavailability to the Service Manager (senior person on duty).

9.3 Data/Information

All information concerned with the reporting and subsequent assessment of concerns or allegations of alleged abuse is subject to the HSE policy on service user confidentiality. However, information regarding or allegations of abuse cannot be received with a promise of secrecy. A person providing such information should, as deemed appropriate, be informed that disclosures of information to appropriate others can occur if:

- A vulnerable person is the subject of abuse and/or
- The risk of further abuse exists and/or
- There is a risk of abuse to another vulnerable person(s) and/or
- There is reason to believe that the alleged person causing concern is a risk to themselves and/or
- A legal obligation to report exists.

All staff must be aware that failure to record, disclose and share information in accordance with this policy is a failure to discharge a duty of care. In making a report or referral, it is essential to be
clear whether the vulnerable person is at immediate and serious risk of abuse and if this is the case, it is essential to outline the protective actions taken. The report/referral may also contain the views and wishes of the vulnerable person where these have been, or can be, ascertained. The role of an advocate or key worker may be important in this regard.

9.4 Records

It is essential to keep detailed and accurate records of concerns or allegations of abuse and of any subsequent actions taken. Local procedures should also contain the necessary documentation to facilitate record keeping. Failure to adequately record such information and to appropriately share that information in accordance with this policy is a failure to adequately discharge a duty of care.
10.0 Stage 1: Responding to Concerns or Allegations of Abuse.

Stage 1 - Concern Arises.

Flow Chart 1

Concern/complaint arises or is raised (e.g. member of public/staff member/other agency, etc.)

Community Setting

- Staff (HSE, Primary Care, other Agency) immediately ensures safety of client
- Staff informs Line Manager / Safeguarding and Protection Team
- Contact An Garda Síochána as appropriate
- Staff outlines in writing all relevant information

Service Setting

- Staff immediately ensure safety of client
- Staff informs Designated Officer and Line Manager
- Line Manager assesses the need for support and/or intervention
- Contact An Garda Síochána as appropriate
- Staff outlines in writing all relevant information

Line Manager/ Safeguarding and Protection Team will ensure that the preliminary screening is undertaken and all necessary actions are taken

Day 1

The Line Manager will notify the Safeguarding and Protection Team

If a Designated Centre, Person in Charge will give notice, in writing, to the Chief Inspector (HIQA)

Proceed to Stage 2 - Preliminary Screening - Section 11.0

NOTE: At any stage in the procedure, if there are significant concerns in relation to a vulnerable person, the Chief Officer (CO) of the Community Healthcare Organisation must be notified immediately. The CO must immediately notify the Director of Social Care. Notification to, and advice from, the National Incident Management Team should be considered in such circumstances and consideration as to whether the concern should be investigated using the HSE Safety Incident Management Policy (2014).
A concern regarding concerns or allegations of abuse of a vulnerable person may come to light in one of a number of ways:

- Direct observation of an incident of abuse.
- Disclosure by a vulnerable person.
- Disclosure by a relative/friend of the vulnerable person.
- Observation of signs or symptoms of abuse.
- Reported anonymously.
- Come to the attention as a complaint through the HSE or agency/organisation complaints process.

The alleged perpetrator may be, for example, a family member, a member of the public, an employee of the HSE or in an organisation providing services. Abuse can take place anywhere - in a service operated by the HSE or in an organisation funded by the HSE. The concern/complaint may also arise in the person’s own home or other community setting.

If unsure that an incident constitutes abuse or warrants actions, the Safeguarding and Protection Team (Vulnerable Persons) is available for consultation.

While respecting everyone’s right to self determination, situations can arise where information is suggestive of abuse and a vulnerable person does not wish to engage. If the risk is of concern, a multi-disciplinary case conference may be appropriate to review and develop possible interventions. Legal advice may also be appropriate.

The following are key responsibilities and actions for any staff member or volunteer who has a concern in relation to the abuse or neglect of a vulnerable adult.

These responsibilities must be addressed on the same day as the alert is raised.

**Immediate Protection.**
Take any immediate actions to safeguard anyone at immediate risk of harm including seeking, for example, medical assistance or the assistance of An Garda Síochána, as appropriate.

**Listen, Reassure and Support.**
If the Vulnerable Adult has made a direct disclosure of abuse or is upset and distressed about an abusive incident, listen to what he/she says and ensure he/she is given the support needed.

Do not:
- Appear shocked or display negative emotions
- Press the individual for details
- Make judgments
- Promise to keep secrets
- Give sweeping reassurances

**Detection and Prevention of Crime.**
Where there is a concern that a serious criminal offence may have taken place, or a crime may be about to be committed, contact An Garda Síochána immediately.
**Record and Preserve Evidence.**
Preserve evidence through recording and take steps to preserve any physical evidence (if appropriate).

**As soon as possible on the same day,** make a detailed written record of what you have seen, been told or have concerns about and who you reported it to. Try to make sure anyone else who saw or heard anything relating to the concern of abuse also makes a written report.

The report will need to include:
- when the disclosure was made, or when you were told about/witnessed this incident/s;
- who was involved and any other witnesses, including service users and other staff;
- exactly what happened or what you were told, using the person’s own words, keeping it factual and not interpreting what you saw or were told;
- any other relevant information, e.g. previous incidents that have caused you concern.

Remember to:
- include as much detail as possible;
- make sure the written report is legible and of a photocopiable quality;
- make sure you have printed your name on the report and that it is signed and dated;
- keep the report/s confidential, storing them in a safe and secure place until needed.

**Report & Inform.**
Report to Designated Officer/ Line Manager as soon as possible. This must be reported on the same day as the concern is raised. The Line Manager must ensure the care, safety and protection of the victim and any other potential victims, where appropriate. He/she must check with the person reporting the concern as to what steps have been taken (as above) and instigate any other appropriate steps.

In the absence of the Designated Officer / Line Manager, the Service Manager must be informed immediately.

The following must be done by the Line Manager and/or Designated Officer:

The Designated Officer or Line Manager must report the concern to the Safeguarding and Protection Team (Vulnerable Persons) within **three working days** after he/she has been informed of the concern.

If the concern relates to a designated centre, the Line Manager must notify HIQA in writing within three working days on the appropriate form. The Line Manager must also notify Tusla **immediately** if there are concerns in relation to children.

Nothing should be done to compromise the statutory responsibilities of An Garda Síochána. If it is considered that a criminal act may have occurred, agreement on engagement with the person who is the subject of the complaint should be discussed with An Garda Síochána.
11.0 Stage 2 – Preliminary Screening.

Note: At any point in the process, it may be appropriate to consult with the HSE Safeguarding and Protection Team (Vulnerable Persons) or An Garda Síochána. In such instances, a written note must be kept of any such consultation.

Flow Chart 2

**Concern Arises (Stage 2)**

- **Community Setting**
  - Line Manager/Safeguarding & Protection Team will carry out a preliminary screening. The purpose of this is to establish if there are reasonable grounds for concern.

- **Service Setting**
  - Designated Officer will carry out a preliminary screening and report findings to the Service Manager. The purpose of this is to establish if there are reasonable grounds for concern.

The outcome of the preliminary screening must be notified to the HSE Safeguarding and Protection Team and actions after this point must be agreed with the HSE

- **Preliminary Screening**
  - No grounds for further investigation
  - Additional information required
  - Reasonable grounds for concern exist. Immediate safety issues addressed

  - Lessons for clinical/care service
  - Immediate safety issues addressed
  - Safeguarding Plan

**3 WORKING DAYS**

**The outcome of any assessment/inquiry following preliminary screening must be reviewed with the Safeguarding and Protection Team (Vulnerable Persons) and a plan to address necessary actions approved.**
11.1 Stages of Preliminary Screening

The Service Manager is responsible for ensuring that the Preliminary Screening takes place. The Preliminary Screening will take account of all relevant information which is readily available in order to establish:

- If an abusive act could have occurred and
- If there are reasonable grounds for concern.

This process should be led by the Designated Officer or other person as determined by the Service Manager and completed, if possible, within 3 working days following the report. Additional expertise may be added as appropriate.

11.1.1 Ensuring Immediate Safety and Support

On receipt of the report of suspected or actual abuse, the Service Manager will establish and document the following:

- What is the concern?
- Who is making the report?
- Who is involved, how they are involved and are there risks to others. What actions have been taken to date?
- Biographical information of those involved, including the alleged perpetrator where appropriate, e.g. name, gender, DOB, address, GP details, details of other professionals involved, an overview of health and care needs (and needs relating to faith, race, disability, age, and sexual orientation as appropriate).
- What is known of their mental capacity and of their wishes in relation to the abuse/neglect?
- Any immediate risks identified, or actions already taken, to address immediate risks.
- Establish the current safety status of the victim. Arrange medical treatment if required.
- Establish if An Garda Síochána have been notified.
- Ensure referral to Tusla where a child is identified as being at risk of harm.

11.1.2 Information Gathering

The Designated Officer or an appropriate staff member appointed by the Service Manager will be appointed to manage the intra and/or inter-agency safeguarding procedure and processes, including co-ordinating assessments.

The person referred should be contacted at the earliest appropriate time. Consent to share or seek information should be addressed at this stage.

It is important to remember that in the process of gathering information, no actions should be taken which may put the person/s referred or others at further risk of harm or that would contaminate evidence.

The types of information to be gathered will be dependent on the individual circumstances of the report. Accordingly, information sources will vary depending on the nature of the referrals but some examples include:

- Gaining the views of the individual referred.
• Checking of electronic/paper files to establish known history of person.
• Checking if there are services already in place and liaison with those services.
• Verifying referral information and gaining further information from the referral source.
• Considering consultation with An Garda Síochána to see if they have any information relating to the person/s referred or alleged perpetrator.

In general, through the information gathering process, the following information should be available:

- Name of person/s referred.
- Biographical details and address/living situation.
- As much detail as possible of the abuse and/or neglect that is alleged to have taken place/is taking place/at risk of taking place (including how it came to light, the impact on the individual, and details of any witnesses).
- The views of the person/s referred and their capacity to make decisions.
- Details of any immediate actions that have taken place (including use of emergency or medical services).
- An overview of the person/s health and care needs (including communication needs, access needs, support and advocacy needs).
- An overview of the persons needs.
- GP details and other health services/professionals.
- Details of other services/professionals involved.
- Name of main carer (where applicable) or name and contact details of organisation providing support.
- Checks made to ensure that the referral is not a duplicate referral.
- Checks made for possible aliases.
- Checks made if other services, teams or allocated workers are involved with the person/s referred or alleged perpetrator/s.
- Checks made for previous concerns of abuse and/or neglect with regards to person/s referred.
- Check for previous concerns of abuse and/or neglect with regards to the alleged perpetrator.

11.1.3 Involvement of staff member:
In situations where the allegation of abuse arises in respect of a member of staff of the HSE or a Non Statutory Organisation funded by the HSE, then the HSE Policies for Managing Allegations of Abuse Against Staff Members will be followed.

11.1.4 Involvement of a service user:
In the event that the concerns or allegations of abuse identified a service user, the plan must ensure that relevant professional advice on the appropriate actions is sought which may include, for example, a behavioural support programme.

The rights of all parties must receive individual consideration, with the welfare of the vulnerable person being paramount.
11.2 Outcome of Preliminary Screening

A report on the Preliminary Screening will be submitted to the Service Manager with a recommendation regarding proposed/required actions.

The report on the Preliminary Screening will be assessed by the Service Manager who will decide on appropriate actions and prepare a written plan for each action.

The report on the Preliminary Screening and the associated plan will be copied to the Safeguarding and Protection Team (Vulnerable Persons) who may advise on other appropriate actions.

Based on the information gathered, an assessment should be made which addresses the following:
- Does the person/s referred or group of individuals affected fall under the definition of Vulnerable Adult (as defined above)?
- Do the concerns referred constitute a possible issue of abuse and/or neglect?
- Where it is appropriate to do so, has the informed consent of the individual been obtained?
- If consent has been refused and the person has the mental capacity to make this decision, is there a compelling reason to continue without consent? Have the risks and possible consequences been made known to the client?

The outcome of the Preliminary Screening may be:
A. No grounds for reasonable concerns exist.
B. Additional information required (this should be specified).
C. Reasonable grounds for concern exist.

11.2.1 No grounds for reasonable concern

An outcome that there are not reasonable grounds for concern that abuse has occurred does not exclude an assessment that lessons may be learned and that, for example, clinical and care issues need to be addressed within the normal management arrangements.

11.2.2 Additional information required

A plan to secure the relevant information and the deployment of resources to achieve this within a specified time will be developed by the Service Manager. This may involve the appointment of a small team with relevant expertise. All immediate safety and protective issues must also be specified.

11.2.3 Reasonable Grounds for Concern Exists

A safeguarding plan must be developed to address the concerns.

The plan may include:
1. Local informal process
2. Internal Inquiry
3. An Independent Inquiry
4. Assessment and management by Safeguarding and Protection Team (Vulnerable Persons).
The outcome of the preliminary screening must be notified to the HSE Safeguarding and Protection Team (Vulnerable Persons) and actions after this point must be agreed with the HSE Safeguarding and Protection Team (Vulnerable Persons).

An Garda Síochána should be notified if the complaint/concern could be criminal in nature or if the Inquiry could interfere with the statutory responsibilities of An Garda Síochána.

An investigation by An Garda Síochána should not necessarily prevent the Inquiry. Where possible agreement should be reached with An Garda Síochána regarding the conduct of the Inquiry and the issuing of a report. If necessary advice should be obtained in this regard.

In 11.2.2 and 11.2.3 above a safeguarding plan must be formulated.

**12.0 Stage 2a The Safeguarding Plan.**

If the preliminary screening determines that reasonable grounds for concern exist a safeguarding plan must be developed. Responsibility to ensure a safeguarding plan is developed rests with the Service Manager.

Prior to the processes outlined in 13.0 stage 3, a safeguarding plan must be developed even if this can only be preliminary in nature. The safeguarding plan will need to be informed and amended by the process determined at 13.0 stage 3.

The Safeguarding Plan will outline the planned actions that have been identified to address the needs and minimise the risk to individuals or groups of individuals.

The Safeguarding Plan will be further developed in line with further assessments, i.e., when the appropriate assessments/investigations have been carried out to establish levels of risk and whether the abuse or neglect occurred. The Safeguarding Plan will be formulated in partnership with all relevant stakeholder parties.

A Safeguarding Plan will be informed by the Preliminary Screening and developed in all cases where reasonable grounds for concern exist.
12.1 Safeguarding Plan Co-ordinator

One lead person must be appointed to act as a co-ordinator of information and intervention. The Safeguarding Plan Co-ordinator will arrange a full review at agreed intervals.

The responsibility for appointment of a Safeguarding Plan Co-ordinator will be with the Service Manager.

If the vulnerable person has capacity and agrees to intervention, a safeguarding plan will be developed, as far as possible, in accordance with his/her wishes.

If the person has capacity and refuses services, every effort should be made to negotiate with the person. Time is taken to develop and build up rapport and trust. It is important to continue to monitor the person’s well being.

If the person lacks capacity, legal advice may be required to inform the decision making process. Decisions must be made in the best interests of the person and, if possible, based on his/her wishes and values. It is not appropriate to take a paternalistic view which removes the autonomy of the vulnerable person.

12.1.1 Timescale

The Safeguarding Plan should be formulated, even in a preliminary form, and implemented within three weeks of the Preliminary Screening being completed. A Safeguarding Plan Review should be undertaken at appropriate intervals and must be undertaken within six months of the Safeguarding Plan commencing and, at a minimum, at six monthly intervals thereafter or on case closure.

12.1.2 Formulating the Safeguarding Plan

The Safeguarding Plan should include, relevant to the individual situation:

- Positive actions to safeguard the person/s at risk from further abuse/neglect and to promote recovery.
- Positive actions to prevent identified perpetrators from abusing or neglecting in the future.

The Safeguarding Plan should also include consideration of what triggers or circumstances would indicate increasing levels of risk of abuse or neglect for individual/s and how this should be dealt with.

12.1.3 Support for Vulnerable Adults

Support measures for Vulnerable Adults who have experienced abuse or who are at risk of abuse should be carefully considered when formulating the Safeguarding Plan. Mainstream support service provision, e.g., Victim Support services, should be considered as well as specialist support services, e.g., specialist psychology services, mediation, etc. The role of An Garda Síochána and related support measures should be considered where a Vulnerable Adult may be going through the criminal justice process, including use of intermediaries, independent advocates, etc.
Where there is a potential for criminal prosecution, it is important to ensure that support is provided to the Vulnerable Adult.

12.1.4 Updating the Safeguarding Plan
Updating and review of the Safeguarding Plan will be informed by all stages of the process. Discussions/meetings on the Safeguarding Plan will be arranged by the Safeguarding Plan Coordinator and should address the following:

- Feedback and evaluation of the evidence and outcomes from the assessments, including making a multi-agency (where appropriate) judgement of whether the abuse/neglect has occurred, has not occurred, or whether this is still not known.
- A review of the initial Safeguarding Plan.
- An assessment of current and future risk of abuse/neglect to the individual, group of individuals, or others.
- To evaluate the need for further assessment and investigation.
- Where abuse/neglect has taken place, or an ongoing risk of abuse/neglect is identified, a Safeguarding Plan should be agreed with proactive steps to prevent/decrease the risk of further abuse or neglect.
- Agreeing an ongoing communication plan, including the level of information that should be fed back to the person who raised the concerns (the referrer), other involved individuals or agencies, and who will be responsible for doing this.
- To set an agreed timescale for further review of the Safeguarding Plan.

12.2 The Safeguarding Plan Review
The Safeguarding Plan Review refers to the planned process of reviewing the actions and safeguards put in place through the Safeguarding Plan. If new or heightened concerns arise prior to the planned Review, these should be addressed in the Safeguarding Plan.

12.2.1 Aims of the Safeguarding Plan Review
The Safeguarding Plan Review should:

- Establish any changes in circumstances or further concerns which may affect the Safeguarding Plan,
- Evaluate the effectiveness of the Safeguarding Plan,
- Evaluate, through appropriate risk assessment, whether there remains a risk of abuse or neglect to the individuals or group of individuals.
- Make required changes to the Safeguarding Plan and set a further review date.

12.2.2 Evaluating the Safeguarding Process
The Safeguarding Plan Review process should also be used as an opportunity to evaluate the intervention in general terms, e.g., what worked well, what caused difficulties, how effectively did people and agencies work together.
This level of information should be fed back through the Safeguarding and Protection Team (Vulnerable Persons) and disseminated to other staff/agencies as appropriate. Experiences from practice, positive and negative, can be used to facilitate learning arising from specific situations to enable services to develop and be in a better position to safeguard individuals at risk from abuse and neglect.

12.2.3 Closing the Safeguarding Plan
The updated risk assessment arising from a Safeguarding Plan Review may provide evidence that the risk of abuse or neglect has been removed, or through changed circumstances, be no longer appropriate to be managed through this procedure. When this occurs, decisions should be taken with multi-agency agreement, where appropriate. Reasons and rationale for closing the Procedure must be recorded in full. The client and/or referrer may be formally notified of closure where appropriate.
13.0 Stage 3: Reasonable Grounds for Concern have been Established.

Flow Chart 3

If it is determined that abuse of a vulnerable person may have occurred, the responsibilities towards all relevant parties must be considered and addressed. These may include:

- The vulnerable person.
- The family of the vulnerable person.
- Other vulnerable persons, where appropriate.
- The perpetrator, particularly if a service user.
- Staff.

The needs of the vulnerable person is the paramount consideration and a formal Safeguarding Plan must be developed which addresses the therapeutic and support needs arising from the experience and the protective interventions aimed at preventing further abuse.

13.1 Outcome of Preliminary Screening

13.1.1 Local Informal Process

If it is established that, for example, a single incident has occurred which is not of a serious nature, the manager may decide to deal with the matter locally and informally. This would usually include training. This approach must be agreed with the vulnerable person. This should be notified to the Safeguarding and Protection Team (Vulnerable Persons).

13.1.2 Inquiry – Internal or Independent

In establishing any form of Inquiry, relevant HSE Policies must be considered. In considering the specific form of Inquiry, issues to be considered include;

- The nature of the concerns.
- If the matters relate to an identifiable person, or incident, or to system issues.
- The impact on confidence in the service.
- The views of the vulnerable persons and/or his/her family.

The Service Manager will usually commission the Inquiry. The Commissioner of an Inquiry must develop specific Terms of Reference and, where appropriate, ensure the appointment of a Chair and members with the suitable experience and expertise, both in services for vulnerable persons and in the application of fair procedures. The Terms of Reference should be informed by
appropriate professional advice. Arrangements for the provision of expert advice to the enquiry should also be outlined.

An Inquiry Report will usually contain certain conclusions and recommendations and it is the responsibility of the Commissioner to receive the report and to determine the necessary actions.

13.1.3 Assessment and Management by Safeguarding and Protection Team (Vulnerable Persons)
In certain circumstances, the HSE Head of Social Care in each Community Healthcare Organisation may decide that the matter should be assessed and managed by the Safeguarding and Protection Team (Vulnerable Persons). Such circumstances may include any possible/perceived conflict of interest for the Service Manager.

The Head of Social Care in each Community Healthcare Organisation may also determine that another process, appropriate to the particular issues arising, is required and may arrange such a process. This may include the arranging of a comprehensive professional assessment.

13.1.4 Management of an Allegation of Abuse against a Staff Member
In situations where the allegation of abuse arises in respect of a member of staff of the HSE or a Non Statutory Organisation funded by the HSE, then the HSE Policies for Managing Allegations of Abuse against Staff Members will be followed.

The safety of the service user is paramount, and all protective measures proportionate to the assessed risk must be taken to safeguard the welfare of the service user.

Nothing should be done to compromise the statutory responsibilities of An Garda Síochána. If it is considered that a criminal act may have occurred, agreement on engagement with the person who is the subject of the complaint should be discussed in the first instance with An Garda Síochána.

14.0 Roles and Responsibilities

14.1 Role of Frontline Personnel

- Promote the welfare of vulnerable person in all interactions.
- Be aware of the services policy and any local procedures, protocols and guidance documents.
- Comply with the policy and procedure to ensure the safeguarding of vulnerable persons from all forms of abuse.
- Support an environment in which vulnerable persons are safeguarded from abuse or abusive practices through the implementation of preventative measures and strategies.
- Avail of any relevant training and educational programmes.
- Be aware of the signs and indicators of abuse.
- Support vulnerable persons to report any type of abuse or abusive practice.
- Ensure that any concerns or allegations of abuse are reported in accordance with the policy.
14.2 Role of Service Manager/Line Managers in both HSE Services and Service Providers

- Ensure that a local policy for the safeguarding of vulnerable persons is in place and is compliant with this national policy.
- Ensure that local procedures are developed to support the implementation of HSE policy and procedures.
- Promote a culture of zero tolerance for any type of abuse or abusive practice.
- Ensure that the policy and procedures are made available to all employees and volunteers and to all persons accessing services and their advocates/families in an accessible format.
- Maintain a record of all employees and voluntary staff members “sign off” on policies/procedures/guidelines pertaining to the safeguarding of vulnerable persons.
- Ensure that all employees / volunteer staff receive the appropriate training with regard to the implementation of this policy.
- Ensure safeguarding is part of the Induction Programme for everyone involved in the service.
- Ensure that any concerns or allegations of abuse are managed in accordance with the policy.

14.3 Role of the Head of Social Care

- Ensure that local policies and procedures developed by HSE services and service providers are compliant with national policy.
- Ensure that service providers have in place arrangements to support the implementation of policy as specified in the Service Agreement/Contract.
- Provide guidance and support to service providers.
- Review on a quarterly basis all concerns or allegations of abuse and their current status.
- Manage the Safeguarding and Protection Team (Vulnerable Persons).

14.4 Role of the Safeguarding and Protection Team (Vulnerable Persons)

**Safeguarding and Protection Team (Vulnerable Persons).**

In each CHO, a Safeguarding and Protection Team (Vulnerable Persons) is being developed to support the objectives of this Policy.

The Safeguarding and Protection Team will:

- Receive reports of concerns and complaints regarding the abuse of vulnerable persons.
- Support services and professionals to assess and investigate the concern(s)/complaint(s) and develop intervention approaches and protection plans.
- Directly assess particularly complex complaints and coordinate service responses.
- Support, through training and information, the development of a culture which promotes the welfare of vulnerable persons, and the development of practices which respond appropriately to concerns or allegations of abuse of vulnerable persons.
- Maintain appropriate records.
14.5 Role of Designated Officer

Each service (HSE and funded) providing services to people who may be vulnerable will appoint a Designated Officer. This appointment is the responsibility of the Senior Manager in the service. The Designated Officer should receive specific training on the legal and policy context in which safeguarding occurs and maintain a familiarity with key practice issues.

The Designated Officer will be responsible for:
- Receiving concerns or allegations of abuse regarding vulnerable persons
- Collating basic relevant information
- Ensuring the appropriate manager is informed and collaboratively ensuring necessary actions are identified
- Ensuring all reporting obligations are met (internally to the service and externally to the statutory authorities)
- Supporting the manager and other personnel in addressing the issues arising.
- Maintaining appropriate records.

Note: These functions are those relevant to receiving and responding to concerns and complaints of abuse.

15.0 Notification

A. An Garda Síochána
An Garda Síochána must be informed if it is suspected that the concern or complaint of abuse may be criminal in nature; this may become apparent at the time of disclosure or following the outcome of the preliminary assessment.

B. HIQA
In designated centres there is a requirement for the person in charge of a designated centre to report in writing to the Chief Inspector (HIQA) within 3 working days any adverse incident when the injury is deemed to be a consequence of an alleged, suspected or confirmed incident of abuse.

C. HSE Good Faith Reporting
The HSE has a Good Faith Reporting Policy for employees who do not wish to make a protected disclosure. The HSE will provide support and advice where necessary to the employee who reports genuine concerns of fraud or malpractice in the organisation.

Good faith reports made to the Information Officer will be referred to the relevant HSE officer for investigation. The Information Officer will not disclose the identity of the employee making the good faith report where the employee so instructs.

In general, employees’ identities will not be disclosed without prior consent. Where concerns cannot be resolved without revealing the identity of the employee raising the concern the HSE will enter into a dialogue with the employee concerned as to whether and how it can proceed. (Good Faith Reporting Policy, 2009).
D. Protected Disclosures
Section 103 of the Health Act 2007 and the Protected Disclosures Act 2014 provide for the making of protected disclosures by health service employees. If an employee reports a workplace concern in good faith and on reasonable grounds in accordance with the procedures outlined in the legislation it will be treated as a ‘protected disclosure’. This means that if an employee feels that they have been subjected to detrimental treatment in relation to any aspect of their employment as a result of reporting their concern they may seek redress. In addition, employees are not liable for damages as a consequence of making a protected disclosure. The exception is where an employee has made a report which s/he could reasonably have known to be false.

Procedure for making a Protected Disclosure
The HSE has appointed an ‘Authorised Person’ to whom protected disclosures may be made. Employees are required to set out the details of the subject matter of the disclosure in writing on the Protected Disclosures of Information Form and submit it to the Authorised Person at the following address:

HSE Authorised Person,
P.O. Box 11571,
Dublin 2.
Tel: 01-6626984.

The Authorised Person will investigate the subject matter of the disclosure. Confidentiality will be maintained in relation to the disclosure insofar as is reasonably practicable. However, it is important to note that it may be necessary to disclose the identity of the employee who has made the protected disclosure in order to ensure that the investigation is carried out in accordance with the rules of natural justice.

E. In certain limited circumstances, an employee may make a protected disclosure to a Scheduled body or a professional regulatory body.
Section 3: Self-Neglect
16.0 Self-Neglect

The Health Service Executive is committed to the protection of vulnerable persons who seriously neglect themselves and is concerned with vulnerable persons where concern has arisen due to the vulnerable person seriously neglecting his/her own care and welfare and putting him/herself and/or others at serious risk.

Responding to cases of self-neglect poses many challenges. The seriousness of this issue lies in the recognition that self-neglect in vulnerable persons is often not just a personal preference or a behavioural idiosyncrasy, but a spectrum of behaviours associated with increased morbidity, mortality and impairments in activities of daily living. Therefore, self-neglect referrals should be viewed as alerts to potentially serious underlying problems requiring evaluation and treatment (Naik et al, 2007).

Family, friends and community have a vital role in helping vulnerable people remain safe in the community. Visiting, listening and volunteer driving are examples of ways to reduce isolation. People wish to respect autonomy and may not wish to be intrusive. However, if concerned or aware of a significant negative change in behaviour, do consider making contact or alerting services.

The purpose of this Policy and Procedures is to offer guidance to staff of the HSE and of organisations in receipt of funding from the HSE who become aware of concerns regarding extreme self-neglect. It also offers guidance to Safeguarding and Protection Teams (Vulnerable Persons) when referrals are received or where advice and support is sought. Cases of self-neglect may require multi-disciplinary and/or multi-agency involvement.

This applies to all HSE services and those organisations in receipt of funding from the HSE. Non-statutory organisations should have their own procedures for the management of situations of extreme self-neglect consistent with this document.

17.0 Definitions

17.1 Self-neglect:

- Self-neglect is the inability or unwillingness to provide for oneself the goods and services needed to live safely and independently.
- A vulnerable person’s profound inattention to health or hygiene, stemming from an inability, unwillingness, or both, to access potentially remediating services.
- The result of an adult’s inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks.
- The failure to provide for oneself the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain.
• Self-neglect in vulnerable adults is a spectrum of behaviours defined as the failure to, (a) engage in self-care acts that adequately regulate independent living or, (b) to take actions to prevent conditions or situations that adversely affect the health and safety of oneself or others.

17.2 Groups that may present with self-neglecting behaviours.

• Those with lifelong mental illness.
• Persons with degenerative neurocognitive disorders such as dementia or affective disorders such as depression.
• Those whose habit of living in squalor is a long-standing lifestyle with no mental or physical diagnosis (Poythress, 2006: 11).
• Self-neglect is common among those who consume large quantities of alcohol; the consequences of such drinking may precipitate self-neglect (Blondell, 1999).
• Those who live alone, in isolation from social support networks of family, friends and neighbours (Burnett et al, 2006).

Self-neglect can be non-intentional, arising from an underlying health condition, or intentional, arising from a deliberate choice.

18.0 Guiding Principles

1. Self-neglect occurs across the life span. There is a danger in targeting vulnerable persons and the decisions they make about lifestyle, which society may find unacceptable.
2. The definition of self-neglect is based on cultural understandings and challenges cultural values of cleanliness, hygiene and care. It can be redefined by cultural and community norms and professional training.
3. A threshold needs to be exceeded before the label of self-neglect is attached – many common behaviours do not result in action by social or health services or the courts.
4. Distinguish between self-neglect, which involves personal care, and neglect of the environment, manifested in squalor and hoarding behaviour.
5. Recognition of the community aspects or dimensions rather than just an individualistic focus on capacity and choice: some self-neglecting behaviour can have a serious impact on family, neighbours and surroundings.
6. Importance of protection from harm and not just ‘non-interference’ in cases of refusal of services. Building trust and negotiation is critical for successful intervention.
7. Interventions need to be informed by the vulnerable person’s beliefs regarding the stress experienced by Care Givers, including family members, and must address the underlying causes.
8. Assumptions must not be made regarding lack of mental capacity and, as far as possible, people must be supported in making their own decisions.
19.0 Manifestations of Self-Neglect

19.1 Hygiene
Poor personal hygiene and/or domestic/environmental squalor; hoarding behaviour (Poythress et al, 2006; Mc Dermott, 2008).

19.2 Life Threatening Behaviour
Indirect life threatening behaviour: refusal to eat, drink; take prescribed medications; comply with an understood medical regime (Thibault et al, 1999)

19.3 Financial
Mismanagement of financial affairs.

20.0 Assessment of Self-Neglect: Key Areas

<table>
<thead>
<tr>
<th>Area / Domain</th>
<th>Evidence of Serious/Severe Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Appearance: hair, nails, skin, clothing, insect infestation</td>
<td>Matted, dirty hair; long, untrimmed, dirty nails; multiple or severe pressure ulcers, other injuries; very soiled clothing; multiple insect infestation.</td>
</tr>
<tr>
<td>Functional Status: cognitive; delusional state; response to emergencies; Medical needs</td>
<td>Impaired cognition; delusional state; unable to call for help or respond to emergencies. No documentation of a health care provider; untreated conditions, appears ill or in pain or complains of pain or discomfort.</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Nutritional deficiencies are significant. It is difficult to assess food storage, availability of food groups and expiry dates.</td>
</tr>
</tbody>
</table>

21.0 Procedures

Consider the possibility.

- Concerns regarding extreme neglect can arise for a variety of people in diverse circumstances. It is critical that one remains open to considering the possibility that a vulnerable person may not be acting in his/her own interest and that his/her welfare is being seriously compromised.

- Considering the possibility of extreme self neglect is a professional responsibility and a service to the person.

- Discuss the concerns with appropriate people and directly with the vulnerable person.

- If concerns cannot be addressed directly, they should be directed to the Safeguarding and Protection Team (Vulnerable Persons) who will assist in an assessment of the severity of the situation.

Approach

- As far as possible and appropriate the Safeguarding and Protection Team (Vulnerable Persons) will support professionals and services in undertaking assessment and intervention.

Assessment:

- On receiving a report of concern about a vulnerable person neglecting himself/herself, the professional/service receiving the report will begin the process of preliminary assessment.

- The Professional/Service will establish whether the vulnerable person is aware of the referral and his/her response to the person making the referral.

- The Professional/Service will consult with other health and social care professionals in order to gain further information. The focus of this preliminary process is to establish the areas of concern, i.e. the manifestations of self-neglect and the perception of those making the referral of the potential harm to which the vulnerable person and/or others are exposed.

- The Professional/Service will establish if there have been any previous attempts to intervene and the outcome of such attempts/interventions.

- The Professional/Service will arrange for an appropriate person to meet the vulnerable person to ascertain his/her views and wishes.

- The Professional/Service may arrange a multidisciplinary strategy meeting, where a decision can be reached as to the person best placed to take a lead role.

- A comprehensive assessment may need to be undertaken by a relevant specialist. This will require a GP referral. Where there is a doubt about the person’s capacity to make decisions and/or to execute decisions regarding health, safety and independent living, the assessment should include specific mental competency assessment. If it is not possible to engage a vulnerable person in obtaining such an assessment, it may be appropriate to seek legal advice.
Safeguarding Plan:

- One lead person must be appointed to act as a co-coordinator of information and intervention. The lead person will arrange a full review at agreed intervals.

- The responsibility for appointment of a lead person will be with the Manager in the service or area involved.

- If the vulnerable person has mental capacity and agrees to intervention, a Safeguarding Plan will be developed in accordance with his/her wishes.

- If the person has mental capacity and refuses services, every effort is made to negotiate with the person. Time is taken to develop and build up rapport and trust. It is important to continue to monitor the person’s well being.

- If the person lacks mental capacity, legal advice may be required to inform the decision making process. Decisions must be made in the best interests of the person and, if possible, based on his/her wishes and values. However, it is not appropriate to take a paternalistic view which removes the autonomy of the vulnerable person.

Review:

- The lead person will arrange a full review of the Safeguarding Plan at agreed intervals.

- The vulnerable person’s situation must be kept under review, as appropriate and deemed necessary

- Family, friends and community have a vital role in helping vulnerable people remain safe in the community.

- The Safeguarding and Protection Team (Vulnerable Persons) will be available to provide advice and support as appropriate.
CONSIDER THE POSSIBILITY OF SELF NEGLECT

ASSESSMENT

SAFEGUARDING PLAN

REVIEW

- REVIEW CLIENT HISTORY
- CONSULTATION WITH CLIENT
- CONSULTATIONS WITH OTHER HEALTH CARE STAFF
- CONSULTATION WITH FAMILY/CARERS
- ASSESSMENT BY SPECIALIST

- APPOINT LEAD PERSON
- DEVELOP SAFEGUARDING PLAN
- LEGAL ADVICE
Section 4: Implementation
22.0 Organisational Arrangements

The National Social Care Division will have responsibility for implementation, monitoring and review of this policy and procedures.

22.1 Review of National Policy and Procedure

The Social Care Division will review this Policy and Procedure after one year and subsequently on a biennial basis, or otherwise as may be appropriate, for example, due to legislative changes and/or from feedback.

22.2 National Office for Safeguarding Vulnerable Persons.

A National Office is being established to provide leadership, oversight and co-ordination for all aspects of policy and practice in relation to the safeguarding of vulnerable persons.

The National Office will

- Support the National Intersectoral Committee, the Dedicated Implementation Working Group and the Interagency Working Group.
- Collect and collate data in relation to referrals of abuse of vulnerable persons.
- Prepare and produce an annual report on the abuse of vulnerable persons.
- Commission research to establish best practice in promoting the welfare and protection of vulnerable persons from abuse.
- Develop and maintain a framework for risk assessment and intervention planning.
- Act as a resource for information in relation to abuse of vulnerable persons.
- Develop public awareness campaigns, ongoing staff training, etc.
- Develop practice guidance and tailored resources for all stakeholders.
- Support the accountability and reporting obligations of the HSE.

22.3 Dedicated Implementation Working Group

A dedicated Implementation Working Group has been established within the Social Care Division and will lead on the roll-out and implementation of this policy and procedures. This Working Group comprises staff from both Older Persons’ Services and Disability Services and will develop a comprehensive Implementation Plan with associated timelines. This Working Group will, for example, develop the appropriate training resources for all personnel and summary material regarding this policy and procedure in an appropriate format for service users, relatives and members of the public. It will also develop appropriate templates to support the processes, e.g., referrals, screening, etc.
22.4 National Inter-Sectoral Committee for Safeguarding Vulnerable Persons

A National Inter-Sectoral Committee for Safeguarding Vulnerable Persons will be established which will:

- Be independently chaired.
- Provide strategic direction.
- Be representative of relevant personnel, and agencies.
- Lead on promoting a societal and organisational culture which promotes the welfare of vulnerable persons.
- Develop a national plan for the promotion of the welfare and protection from abuse of Vulnerable Persons, for consideration by the Social Care management team, and for inclusion in the Annual Service Plan as appropriate.
- Provide oversight and guidance on policies and procedures required to ensure complaints and concerns are addressed appropriately.
- Develop and review HSE Policies and Procedures regarding Vulnerable Persons.
- Ensure that information gathering and analysis systems operate to inform effective management and learning.
- Propose the commissioning of research, public awareness campaigns, and training aimed at promoting the welfare of vulnerable persons.
- Report on an agreed basis to the National Director - Social Care.
- Contribute, as agreed, to relevant activities and initiatives.

The National Committee will maintain two sub-committees, one focusing on elder abuse and one on abuse of persons with a disability.

22.5 National Inter-agency Working Group

A National Inter-agency Working Group will be established in association with An Garda Síochána and TUSLA (Child & Family Agency) to develop joint protocols and collaborative arrangements.

22.6 Safeguarding and Protection Committee (Vulnerable Persons).

Within each Community Healthcare Organisation a Safeguarding and Protection Committee will be appointed by the Chief Officer and will

- Represent relevant personnel and agencies.
- Be chaired by the Head of Social Care.
- Support the development of a culture within the area and within services which promotes the welfare of vulnerable persons.
- Develop, approve and have oversight of the area plan to promote the welfare of vulnerable persons, consistent with Service Plan objectives.
• Support interagency communication and collaboration in respect of services and responses to the needs of vulnerable persons.
• Provide a support and advisory service to the Senior Manager and Safeguarding and Protection Team (Vulnerable Persons) in addressing the needs of vulnerable persons, including consideration of particularly complex cases and system issues.
• Contribute, as agreed, to relevant activities and initiatives.

22.7 Head of Social Care
The Head of Social Care will have overall management responsibility within the CHO for the promotion of the welfare of vulnerable persons and ensuring that policies, procedures and systems within the CHO and relevant organisations are operating effectively in order to ensure appropriate responses to concerns and allegations of abuse of vulnerable persons.

The Head of Social Care will:
• Chair the CHO Committee.
• Support the development of a culture within services and organisations which promotes the welfare of vulnerable persons.
• Provide or ensure appropriate management for the Safeguarding and Protection Team.
• Support and be responsible for the effective operation of the Safeguarding and Protection Committee.
• Ensure the development of the area plan and the achievement of Service Plan objectives.
• Develop and maintain interagency arrangements to ensure effective communication and collaboration.
• In collaboration with the Safeguarding and Protection Team (Vulnerable Persons) and the Area Committee identify systemic areas of concern in the operation of services and organisations which impact on vulnerable persons and ensure that these are addressed.
• Provide leadership, support and direction in ensuring appropriate responses to cases of particular complexities.
• Establish robust information systems and prepare reports on the operation of the service.
• Ensure the appropriate provisions are included in service agreements and contracts.
• Undertake other relevant duties as may be directed by the Area Manager.

22.8 Safeguarding and Protection Team (Vulnerable Persons)
A Safeguarding and Protection Team (Vulnerable Persons) will be established in each CHO.

The Safeguarding and protection Team will work collaboratively with services and professionals in:
• Promoting the welfare of vulnerable persons.
• Acting as a resource to personnel and services having concerns regarding vulnerable persons.
• Receiving concerns and complaints regarding vulnerable persons.
• Assessing concerns and complaints involving vulnerable persons.
• Advising on and in complex situations undertaking assessments regarding possible abuse of vulnerable persons.
• Developing, or ensuring the development of interventions and Safeguarding Plans, and reviewing the effectiveness of such plans.
• Working collaboratively with relevant agencies in addressing issues impacting on the welfare of vulnerable persons.
• Maintaining records and reporting on the service.
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McDermott, S. The Devil is in the Details: Self-Neglect in Australia. *Journal of Elder Abuse and Neglect* 20 (3), 231- 250.


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Prevention in adult safeguarding, Social Care Institute for Excellence, UK May 2011

Scheme of Criminal Justice (Withholding Information on Crimes against Children and Vulnerable Adults) Bill 2011.


Appendices
Appendix 1

The following table provides definitions, examples and indicators of abuse with which all staff members must be familiar.

<table>
<thead>
<tr>
<th>Type of Abuse: Physical</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td><strong>Physical abuse</strong> includes hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions.</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>Hitting, slapping, pushing, burning, inappropriate restraint of adult or confinement, use of excessive force in the delivery of personal care, dressing, bathing, inappropriate use of medication.</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
<td>Unexplained signs of physical injury – bruises, cuts, scratches, burns, sprains, fractures, dislocations, hair loss, missing teeth. Unexplained/long absences at regular placement. Service user appears frightened, avoids a particular person, demonstrates new atypical behaviour; asks not to be hurt.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Abuse: Sexual</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Sexual abuse includes rape and sexual assault, or sexual acts to which the vulnerable person has not consented, or could not consent, or into which he or she was compelled to consent.</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>Intentional touching, fondling, molesting, sexual assault, rape. Inappropriate and sexually explicit conversations or remarks. Exposure of the sexual organs and any sexual act intentionally performed in the presence of a service user. Exposure to pornography or other sexually explicit and inappropriate material.</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
<td>Trauma to genitals, breast, rectum, mouth, injuries to face, neck, abdomen, thighs, buttocks, STDs and human bite marks.</td>
</tr>
<tr>
<td></td>
<td>Service user demonstrates atypical behaviour patterns such as sleep disturbance, incontinence, aggression, changes to eating patterns, inappropriate or unusual sexual behaviour, anxiety attacks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Abuse: Emotional/Psychological (including Bullying and Harassment)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Psychological abuse includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>Persistent criticism, sarcasm, humiliation, hostility, intimidation or blaming, shouting, cursing, invading someone’s personal space. Unresponsiveness, not responding to calls for assistance or deliberately responding slowly to a call for assistance. Failure to show interest in, or provide opportunities for a person’s emotional development or need for social interaction. Disrespect for social, racial, physical, religious, cultural, sexual or other differences. Unreasonable disciplinary measures / restraint. Outpacing – where information /choices are provided too fast for the vulnerable person to understand, putting them in a position to do things or make choices more rapidly than they can tolerate.</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
<td>Mood swings, incontinence, obvious deterioration in health, sleeplessness, feelings of helplessness / hopelessness, Extreme low self esteem, tearfulness, self abuse or self destructive behaviour.</td>
</tr>
<tr>
<td></td>
<td>Challenging or extreme behaviours – anxious/ aggressive/ passive/withdrawn.</td>
</tr>
</tbody>
</table>
### Type of Abuse: Financial

**Definition**

Financial or material abuse includes theft, fraud, exploitation, pressure in connection with wills property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

**Examples**

Misusing or stealing the person’s property, possessions or benefits, mismanagement of bank accounts, cheating the service user, manipulating the service user for financial gain, putting pressure on the service user in relation to wills property, inheritance and financial transactions.

**Indicators**

No control over personal funds or bank accounts, misappropriation of money, valuables or property, no records or incomplete records of spending, discrepancies in the service users internal money book, forced changes to wills, not paying bills, refusal to spend money, insufficient monies to meet normal budget expenses, etc.

### Type of Abuse: Institutional

**Definition**

Institutional abuse may occur within residential care and acute settings including nursing homes, acute hospitals and any other in-patient settings, and may involve poor standards of care, rigid routines and inadequate responses to complex needs.

**Examples**

Service users are treated collectively rather than as individuals. Service user’s right to privacy and choice not respected. Staff talking about the service users personal or intimate details in a manner that does not respect a person’s right to privacy.

**Indicators**

Lack of or poor quality staff supervision and management. High staff turnover. Lack of training of staff and volunteers. Poor staff morale. Poor record keeping. Poor communication with other service providers. Lack of personal possessions and clothing, being spoken to inappropriately, etc.

### Type of Abuse: Neglect

**Definition**

Neglect and acts of omission include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating.

**Examples**

Withholding or not giving help that a vulnerable person needs so causing them to suffer e.g. malnourishment, untreated medical conditions, unclean physical appearance, improper administration of medication or other drugs, being left alone for long periods when the person requires supervision or assistance.

**Indicators**

Poor personal hygiene, dirty and dishevelled in appearance e.g. unkempt hair and nails. Poor state of clothing. Non attendance at routine health appointments e.g. dental, optical, chiropody etc. socially isolated i.e. has no social relationships.

### Type of Abuse: Discriminatory

**Definition**

Discriminatory abuse includes ageism, racism, sexism, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

**Examples**

Shunned by individuals, family or society because of age, race or disability. Assumptions about a person’s abilities or inabilitys.

**Indicators**

Isolation from family or social networks.
Safeguarding Vulnerable Persons at Risk of Abuse
National Policy & Procedures
Incorporating Services for Elder Abuse and for Persons with a Disability

Social Care Division
## Indwelling Urinary Catheter Change Record

**Name:** __________________________  **DOB:** ________________  **MRN:** ________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Days in situ</th>
<th>Verbal consent obtained</th>
<th>Vol. of sterile water removed</th>
<th>Findings of visual inspection of catheter lumen &amp; tip (1)</th>
<th>Reason for change</th>
<th>Vol. of sterile water inserted</th>
<th>Catheter draining urine post insertion</th>
<th>Date of next planned change</th>
<th>Complete “My urinary catheter passport”</th>
<th>Signature</th>
<th>Affix Adhesive catheter label (2)</th>
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<tbody>
<tr>
<td></td>
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<td>Yes □  No □</td>
<td>____mls</td>
<td>Planned__ Blocked__ Other___</td>
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</tbody>
</table>

1. Inspect tip & lumen - record findings. If blocked, cut catheter longitudinally & record findings as either clear, soft mucus or mineral encrustation
2. Adhesive label records catheter name & type, size, Lot/Batch number and expiry

*Guideline on Indwelling Urinary Catheter Management for Adults, PHN Services, 2018*
**Indwelling Urinary Catheter Change Record**

<table>
<thead>
<tr>
<th>Name:________________</th>
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1. Inspect tip & lumen - record findings. If blocked, cut catheter longitudinally & record findings as either clear, soft mucus or mineral encrustation
2. Adhesive label records catheter name & type, size, Lot/Batch number and expiry date.

*Guideline on Indwelling Urinary Catheter Management for Adults, PHN Services, 2018*
### Indwelling Urinary Catheter Template for Care Plan Development

<table>
<thead>
<tr>
<th>Date</th>
<th>Assessed Need</th>
<th>GOAL</th>
<th>INTERVENTION</th>
<th>Evaluation of intervention/Goals &amp; review date</th>
<th>SIGNATURE</th>
</tr>
</thead>
</table>

|     | __________ has an indwelling urethral or suprapubic catheter in place due to | To minimise the risk of acquiring a CAUTI | • Review the continued clinical indication for use. | A urinary catheter should be a last resort when all other options have been considered and the continued clinical need reviewed. Providing information reduces anxiety          |          |
|     | • Acute urinary retention | Early recognition of the signs and symptoms of UTI allowing for prompt treatment | • Ensure client/family/carer are given information regarding the reason for insertion of the catheter, plan for review and replacement as per “My Urinary Catheter Passport” HSE South, 2018 | Good hand hygiene reduces the risk of cross infection |          |
|     | • Chronic urinary retention | | • Prior to insertion of a urinary catheter explain and discuss the procedure with the client/family/carer obtaining consent and always checking for any known allergies (latex/anaesthetic gel) | Reduces the risk of cross infection |          |
|     | • Comfort/palliative care | | • Ensure that the correct principles of hand hygiene are adhered to before and after direct client care (HPSE, 2015) | |          |
|     | • Healing of sacral/perineal wounds | | • Maintain clients dignity and respect at all times by ensuring that they are in a comfortable position and not exposed before the urinary catheter insertion procedure commences | |          |
|     | Therefore, __________ has an increased risk of acquiring a catheter Associated Urinary Tract Infection (CAUTI). | | • Maintain a sterile closed drainage system | |          |
with the choice of urine bags based on individual assessment and in line with local policy (HSE South, Urinary Catheter Care, 2018)

- Secure the catheter tubing with a stabilisation device either adhesive or straps (if appropriate and suitable) to the thigh or abdomen to minimise the risk of accidental traction on the catheter preventing potential trauma to the bladder and urethra
- Secure the drainage bag with either straps or sleeve as appropriate
- Advise the client/family/carer that the IUC will be changed at least every ____ weeks or when clinically indicated
- Advise the family that the catheter bag/leg bag will be changed once a week
- Advise the client/family/carer that the urine bag has to be emptied on a regular basis (when 2/3 full) to prevent the catheter pulling due to the weight of the urine.
- Advise client/family/carer that a sterile single use urine bag is to be attached each night and disposed of in the morning – empty the bed bag before disposal in household waste.
- Always document, urinary catheter changes in “Indwelling urinary catheter change record” i.e. date, reason for insertion, consent, catheter type, amount of water instilled into the balloon, manufacture and batch number with the signature of the nurse undertaking the urinary catheter procedure.

infection

Clinical indications for more frequent change of a Urinary catheter
- Catheter encrustations
- Leakage
- Bleeding
- Catheter associated UTI

Documentation provides point of reference/comparison in the event of later queries
<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue My Urinary Catheter Passport (if not already provided)</td>
<td></td>
</tr>
<tr>
<td>Educate the client/family/carer on Urinary Catheter management in association with the Urinary Catheter Passport on the importance of proper hand hygiene, catheter hygiene &amp; perineal care, and the importance of cleaning the perineal area from front to back after defecation and also how to clean the urethral meatus with un-perfumed soap and water during the daily bathing/showering routine.</td>
<td></td>
</tr>
<tr>
<td>Instruct the client/family/carer on which signs and symptoms to report to the Public Health Nursing service/General Practitioner, using My Urinary Catheter Passport. i.e. fever, chills, rigors or body aches/malaise, cloudy/bloody urine or pus in the urine or around supra-pubic site/loin/flank pain, renal angle or suprapubic pain, associated nausea/vomiting.</td>
<td></td>
</tr>
<tr>
<td>If CAUTI develops, advise client/family/carer that the catheter should be changed if it has been in place for two weeks or more and is still indicated.</td>
<td></td>
</tr>
<tr>
<td>Advise the client to exercise and to drink 1.5 to 2 litres of fluid, preferably water, a day unless contraindicated</td>
<td></td>
</tr>
<tr>
<td>Increased fluid dilutes urine, reduces irritation and helps to flush out bacteria from the bladder</td>
<td></td>
</tr>
</tbody>
</table>

<p>| Patient requires assistance with catheter care | To support the patient in catheter care management | Delegate care of urinary catheter as outlined in the leaflet “Information and Instruction for Home Helps Caring for Patients with Indwelling Urinary Catheters” to competent and confident formal or informal carer. |</p>
<table>
<thead>
<tr>
<th>Issue information leaflet for inclusion in Home Support Plan as appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urine retention/ catheter not draining:</strong></td>
</tr>
<tr>
<td>- due to blockage</td>
</tr>
<tr>
<td>- displacement</td>
</tr>
<tr>
<td>- mucosal occlusion</td>
</tr>
<tr>
<td>To minimise the risk of the urinary catheter blocking</td>
</tr>
<tr>
<td>- Educate and advise the client to check the tubing of the catheter is not kinked.</td>
</tr>
<tr>
<td>- Ensure that the client/family/carer understands that the catheter bag should never be more than 2/3 full</td>
</tr>
<tr>
<td>- Advise the client/family or carer not to lie or sit on the catheter tubing and to hang the night bag on a catheter stand and not in the bed or on the floor</td>
</tr>
<tr>
<td>- Encourage and advise the client to prevent constipation by eating a high fibre diet with an adequate fluid intake</td>
</tr>
<tr>
<td>- Advise the client/family/carer about the importance of washing the urethral meatus with un-perfumed soap and water during the daily bathing or showering routine</td>
</tr>
<tr>
<td>- Advise the client/family/carer to contact the Public Health Nursing Dept/GP if pain and comfort occur due to the catheter not draining.</td>
</tr>
<tr>
<td>- Change urinary catheter if clinically indicated or seek medical assistance from the GP</td>
</tr>
<tr>
<td>Presence of faeces in the rectum may press against the catheter occluding it</td>
</tr>
<tr>
<td>Formation of crusts around the meatus can cause blockage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By passing/ leakage of urine around the catheter</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Blocked catheter</td>
</tr>
<tr>
<td>- Bladder spasm</td>
</tr>
<tr>
<td>- Incorrect size of catheter</td>
</tr>
<tr>
<td>- Incorrect balloon size</td>
</tr>
<tr>
<td>Minimise the risk of the catheter falling out</td>
</tr>
<tr>
<td>- Ensure that the correct urinary catheter size has been used</td>
</tr>
<tr>
<td>- Ensure that the balloon is inflated as per instructions with no more than 10mls of sterile water</td>
</tr>
<tr>
<td>- Always ensure/advise the client/family and carer that the catheter tubing is secured appropriately to the clients thigh or abdomen</td>
</tr>
<tr>
<td>- Always advise the client/family/carer to</td>
</tr>
<tr>
<td>Reduces urethral trauma, bladder spasm from pressure and traction and allows for adequate drainage</td>
</tr>
<tr>
<td>Altered ability to maintain sexual relations</td>
</tr>
<tr>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Contact the GP/Public Health Nursing Dept if the catheter falls out, always ensuring that there is a spare catheter available in the home.</td>
</tr>
<tr>
<td>If catheter <strong>blocks</strong> check for any obvious blockages. Check the catheter and tubing, gently rotating the catheter in line with guideline to help dislodge any debris. If none evident remove it and re-catheterise using ANTT. Do not use a washout. Once removed – cut catheter lengthways to see what has caused the blockage and record findings.</td>
</tr>
<tr>
<td>If prescribed – commence on catheter maintenance washouts.</td>
</tr>
<tr>
<td>Discuss clients’ needs sensitively</td>
</tr>
<tr>
<td>Advice on suggestions to allow for intercourse, by referring to advice included in “My Urinary Catheter Passport” e.g. using a condom to hold the catheter in place, tapping the catheter tubing securely, use of flip flow valve.</td>
</tr>
</tbody>
</table>
Self-Neglect: Assessment

Nursing & Midwifery Planning & Development Unit Cork & Kerry
Thursday 1\textsuperscript{st} March, 2018
Masterclass - PHN Service Cork/Kerry Community Organisation
Bru Columbanus, Cork
Dr. Mary Rose Day
Objectives

- Background & Context
- Domains of Assessment: Physical/Medical, Psychological/Mental Health, Environment, Financial, Social/Cultural
- Capacity
- Assessment of Self-Neglect
- Ethical Decision Making Framework to explore responses to self-neglect
- Documentation recording decisions, and actions fulfilling legal responsibilities harm reduction
- Self-Neglect Practice
- Lessons from serious case reviews
- Conclusion
Safeguarding Policy Principles

Principles –
• Human Rights;
• Person-Centeredness;
• Advocacy;
• Confidentiality;
• Empowerment;
• Collaboration.

NB Currently HSE undertaking a review of the safeguarding policy. Deficiency in the lack of a legislative framework for assessment, planning and co-ordination in responding to safeguarding concerns and managing interventions (O’Donnell et al., 2017).
Definition of Vulnerable Adults

• A Vulnerable Person is an adult who may be restricted in capacity to guard himself / herself against harm or exploitation or to report such harm or exploitation (HSE, 2014).

• Failure to:
  (a) engage in self-care acts that adequately regulate independent living or,
  (b) to take actions to prevent conditions or situations that adversely affect the health and safety of oneself or others” (HSE, 2014, p.45).
ADVERSE OUTCOMES AND SELF-NEGLECT

Vulnerable self-neglecting adults are characterized by profound and chronic negative sequelae, including:

- significantly greater mortality
- hospitalization
- hospice use
- nursing home placement
- elder abuse
- and risk for homelessness

- 582 cases as extreme self-neglect, and represent 7% of the overall cases. Most of the self-neglect cases (12%, n=440) relate to people in the over 65 age category and 3% (n=131) were aged 18-64 years.

**National Data on Safeguarding (HSE 2016)**
National Safeguarding Committee

Promoting the Rights of Adults who may be vulnerable

The Committee exists to promote positive organisational and societal culture(s) that uphold the rights of adults who may be vulnerable

It will work to ensure that policies and practices are effective in recognising and dealing effectively with vulnerability and its impact on individuals

- Raise public awareness and understanding
- Inform and Influence Government policy
- Promote people’s rights
- Build the Committee’s capacity and capability

Utilising Committee resources
- Communicating and engaging
- Collaborating
- Researching
- Influencing

Sourcing external resources
Safeguarding Vulnerable Adults

(HSE, 2014, p.49)
A fundamental principle of a democratic society is the simple principle

"Nothing about you - without you".
Self-Neglect

Understanding risk factors

Self-Neglect

Physical/Psycho-Social Factors
- Physical Health
- Mental Health
- Personal endangerment
- Social Networks

Environmental Factors
- Personal Living Conditions
- Physical Living Conditions
- Financial Issues

(Iris et al, 2010)
Executive Function and Dysfunction

Executive function (frontal lobe function) is necessary for planning, initiation, organisation, self-awareness and execution of tasks and is critically important for protection and safety and independent living. Executive dysfunction inhibits appropriate decision making and problem solving.

(Hildebrand et al. 2013).

Characteristics of Executive Dysfunction

Inability to complete complex cognitive tasks (i.e. managing finances, identifying dangerous situations)

Inability to maintain adequate hygiene or self-administer medications

(Royall et al., 2005, Dyer et al., 2007)

The presumption of capacity
• Supporting people to maximise capacity and supporting decision-making
• Respecting people’s choices and unwise decisions
• Any intervention should be as limited as possible
• Essential considerations when making an intervention
• The inclusion of other people whose views may be helpful
• Respecting the privacy of the relevant person
Risk Assessment

• Client’s capacity
• Support Network
• Identify repeating patterns occurrence, immanency and frequency of the event and severity of consequences i.e. behaviours
• Addressing immediately presented behaviours and crises, and other events co-occurring paying attention to underlying causes
• Discuss and assess known risks with the individuals concerned i.e. relating to physical health deterioration, alcohol and drug misuse, financial abuse, fluctuating mental health needs, suicidal ideation and self-neglect
• Practice in relation to prescribing and then the monitoring of the impact of medication
• Monitoring of weight, fluid and food intake, and pressure ulcers in care homes, accompanied sometimes by an absence of concerned curiosity or investigation of physical or mental deterioration
• Safety of home environment i.e. fire risk etc.

(Preston-Shoot, 2017, MacLeod & Stadnyk, 2015)
Assessment

• Assessment is a process
• Ensure person remains central
• Contains full, concise relevant accurate information including a chronology/ and or family social history;
• Use observable information not speculation
• Make good use of information from a range of sources;
• Include analysis that makes clear links between recorded information plan for intervention (safeguarding plan) or decisions not to take any further actions –Action or Inaction
• Keep an eye on progress regularly reviewing assessment
Self-Neglect Assessment Measure (Day & McCarthy, 2016, 2017)

- Environment: 12 items
- Social Networks: 7 items
- Emotional & Behavioural Liability: 8 items
- Health Avoidance: 6 items
- Self-Determinism: 4 items
Risk Management

- The assessment and management of risk should promote independence, real choices and social inclusion of vulnerable adults.
- Risks change as circumstances change.
- Risk can be minimised but not eliminated.
- Identification of risk carries a duty to manage the identified risk.
- Involvement with vulnerable persons, their families, advocates and practitioners from a range of services and organisations helps to improve the quality of risk assessments and decision making.
- Defensible decisions are those based on clear reasoning.
- Risk-taking can involve everybody working together to achieve desired outcomes.
- Confidentiality is a right, but not an absolute right, and it may be breached in exceptional circumstances when people are deemed to be at risk of harm or it is in the greater public interest.
- The standards of practice expected of staff must be made clear by their team manager/supervisor.
- Sensitivity should be shown to the experience of people affected by any risks that have been taken and where an event has occurred.
<table>
<thead>
<tr>
<th>Actions</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>1. Articulate the ethical problem(s) and identify relevant facts</td>
<td>Be ethically sensitive and communicate clearly</td>
</tr>
<tr>
<td>2. Identify stakeholders’ interests, needs, values</td>
<td>Be respectful and inclusive</td>
</tr>
<tr>
<td>3. Weigh the merits and demerits of available courses of action</td>
<td>Be informed and fair</td>
</tr>
<tr>
<td>4. Select the action which can best be supported by ethical principles</td>
<td>Be impartial and transparent</td>
</tr>
<tr>
<td>5. Review</td>
<td>Check: have I been sensitive, clear, respectful, inclusive, informed, fair, impartial and transparent?</td>
</tr>
</tbody>
</table>
Some Key Questions on Reflection?

• What are the concerns at this point.
• Does risk assessments clearly incorporate the service user’s perspective?
• Are you seeing the picture clearly or are your views being swayed by the labels this service user has acquired, or their historical reputation? Is it really the person’s ‘choice’ to live in the way that they are? What has brought them to this ‘choice’?
• Is pressure from neighbours making you act in a way that may not necessarily be in the service user’s best interests? Alternatively, have the neighbours got a point?
• What other professionals need to be involved? Can recourse to the law help?
• How can a trusting relationship be built up? How can resources be identified and mobilised to support the service user?
• Is there family?
• Do we need to speak to other professionals and agencies?
## Self-Neglect Practice

(Day et al., 2016, Day & McCarthy, 2017, Braye et al., 2017)

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Legal knowledge</strong></td>
<td>Knowledge and skilled application of legal options and requirements</td>
</tr>
<tr>
<td><strong>Ethical knowledge</strong></td>
<td>Reflective and critical consideration and justification in application of values, rules, principles and actions (Day et al., 2016; Day &amp; McCarthy, 2017; Braye et al., 2017)</td>
</tr>
<tr>
<td><strong>Relationship centred practice</strong></td>
<td>Engaging with people's unique biographies and lived experiences Demonstrating concerned curiosity</td>
</tr>
<tr>
<td><strong>Emotional literacy</strong></td>
<td>Managing stress and anxiety Recognizing the impact of personal orientation to practice</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>Drawing on a wide range of evidence</td>
</tr>
<tr>
<td><strong>Organisational Knowledge</strong></td>
<td>“Understanding accountability and management of practice within a multiagency context Challenging procedures, cultures and decision making where these make error more likely” (Braye et al. 2017, p. 180)</td>
</tr>
<tr>
<td><strong>Decision Making</strong></td>
<td>Sharing of information Managing the multiagency partnership Explicitly weighing the evidence in relation to different options</td>
</tr>
</tbody>
</table>
Legislation and Serious Case Reviews?

- Direct practice with the individual adult;
- Organisational factors that influenced how the practitioners worked;
- How practitioners and agencies worked together;
- The SAB’s interagency governance role (Preston, 2017).

Quality of direct practice with the individual adult
(Preston-Shoot, 2017)

• Risk: Absence or inadequacy of risk assessment, failure to recognise persistent and escalating risks, failure to act commensurate with risk;

• Mental capacity: Missing or poorly performed capacity assessments, and in some cases an absence of explicit best-interests decision-making;

• Making safeguarding personal: (a) Lack of personalised care and focus on needs, wishes and preferences, insufficient contact, reliance on the view of others; (b) Personalisation prioritised to the exclusion of other considerations such as risk to others, reflecting the dilemma between respect for autonomy and self-determination, and a duty of care;

• Challenges of engagement and of balancing autonomy with a duty of care: lack of persistence in working with reluctance to engage, lack of time to build trust and continuity, refusal taken at face value – lifestyle choice;

• Working with family members: failure to involve carers, and/or to recognise their needs, absence of attention to complex family dynamics;

• Understanding history: lack of curiosity about the meaning of behaviour; failure to recognise key features in life histories;

• Transfer between services and settings.
Organisational factors that influence how practitioners work (Preston-Shoot, 2017)

- Safeguarding literacy: knowledge and confidence of staff; failure to recognise safeguarding concerns and cumulative patterns; failure to make safeguarding alerts when these were clearly indicated; reluctance to escalate concerns;
- Records and recording: key information in case documentation absent or unclear; failure to consult records or to ensure that crucial information was read; technology shortcomings that did not identify important information;
- Inadequate resources – workloads, staffing and specialist placements in particular;
- Management oversight of cases: lack of proactive scrutiny; inadequate response to escalation; lack of support and supervision; mismanagement of dual relationships;
- Legal literacy: insufficient knowledge and understanding of legal powers and duties;
- Market features: insufficient contract monitoring; commissioning gaps; insufficiently robust inspections of provision.
- Agency culture: insufficient priority given to matters such as escalation, accountability and dignity; tolerance of poor care standards; missing or unclear policies and guidance; available guidance not followed.
Inter-professional and interagency practice (Preston-Shoot, 2017)

Service coordination: work conducted on multiple parallel lines, lacking coordinating leadership; absence of use of multidisciplinary meetings to establish shared ownership and approach; no overall risk picture; absence of escalation between agencies;

Communication and information-sharing: crucial information not shared or communications not timely; protocols not used;

Absence of safeguarding literacy: failures to implement safeguarding procedures; inadequate responses to safeguarding alerts; absence of challenge to poor service standards;

Shared records: invisibility of key records to other agencies/professionals; absence of single record systems;

Thresholds for services: inflexible use means risks and needs not addressed;

Legal literacy: misunderstanding of the legal rules; agencies failing to consider together how legal powers and duties could be exercised in a joint strategy.
Conclusions

• Self-neglect is a growing serious, and complex public health issue
• Knowledge and skilled application of legal options and requirements
• Mental health issues are associated with and significant risk for self-neglect
• An objective assessment measurement tool has potential to reduce or prevent negative health outcomes
• Each case is unique relationship based practice making safeguarding personal understanding the persons life history and seeking positive engagement over time
• Interprofessional and interagency collaboration
• An ethical approach to decision-making
• Devising flexible responses and interventions
• Supervision and support.
Reading Prior to Masterclass


• Health Service Executive (2014). *Safeguarding Vulnerable Persons at Risk of Abuse National Policies and Procedures* Social Care Division, HSE, Kildare
References


Self-Neglect Assessment

Please mark responses with an X or use the space to enter a written response where applicable.

N.B. Never use a Risk Assessment Tool as a substitute for overview and review or reassessment.

Referred by: ______________

Date of first contact: ______________ Date of completion of assessment: ______________

Reassessment Date: ______________

Assessors Name: ______________________________

☐ PHN ☐ Community Nurse ☐ Social Worker ☐ Senior Case Worker

☐ Other

Has the client/individual been assessed previously ☐ Yes ☐ No

Name of Client ____________________________________________

Address __________________________________________________

Age of older adult: _________ Gender ☐ Female ☐ Male

Does the person own or rent his/her own home: Owns ☐ Rents ☐ Someone else owns/rents ☐

Risk Assessment

Is elder abuse suspected? ☐ Yes ☐ No

Please indicate the overall risk level for this older adult: ☐ High ☐ Moderate ☐ Low

Action

☐ Safeguarding concerns refer to safeguarding team ☐ Refer to multidplinary team for case managment

☐ Needs assistance and case management ☐ Safeguardingaurding plan ☐ Other

Please respond to each item and based upon your professional judgement, and reports from the older adult directly or from a third party neighbour family etc. Please complete assessment using current avilable information and answer yes/don’t know or no. There is a comment box at the end of the Self-Neglect Assesssment Instrument (SN-7) where you can document further information.

Environment (12 Items)

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<tr>
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<th>Yes</th>
<th>Don’t Know</th>
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<td></td>
<td>1</td>
<td>0</td>
<td>0</td>
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</table>

1. Individual has no way to obtain and/or prepare meal
2. Individual lives in a house/apartment that does not
have all the equipment/facilities to fit the individual's
Physical needs (i.e. bars in the bathroom or hallway
or ramps, poor lighting, fuel poverty etc.).
3. Individual has an accumulation of items that present a
safety hazard
4. Individual lives in a house/apartment that is very cold
5. Individual lives in a house/apartment that is unsafe
   (i.e. fire hazards, reduced accessibility)
6. Individual is hoarding animals
7. Individual is eating spoiled food
8. Individual has no access to bathing facilities
9. Individual lacks funds/money to pay bills (i.e. household
   repairs, utilities etc.)
10. Individual lives in a house/apartment where there is
evidence of vermin
11. Individual does not pay household bills despite having
    adequate income to pay them
12. Individual lives in a house/apartment where utilities
    are not working

Social Networks  (7 Items)

13. Individual is living alone
14. Individual is socially disconnected or has limited social
    relationships with neighbours
15. Individual has not talked to someone in past week
16. Individual lacks social contact (family, friends) to turn to in
    an emergency
17. Individual avoids friends, family social events religious
18. Individual’s contact with family, friends, neighbours is less
    frequent than necessary to attend to his/her needs
19. Individual does not have anyone to provide him/her with
    the assistance she/he needs

Emotional and Behavioral Liability (8 items)
20. Individual displays fear in daily situations
21. Individual expresses fear of certain people who are close
    to him/her
22. Individual demonstrates aggressive hostile behavior

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23. Individual is placing trust in people who have proven to be untrustworthy
24. Individuals behaviors are likely to cause physical harm to others
25. Individual has not left his/her house/apartment for one month
26. Individual appears sad (gloomy, mournful, suicidal ideation)
27. Individual is overusing drugs/alcohol

**Health Avoidance (6 items)**
28. Individual has unattended foot problems
29. Individual ignores signs and symptoms of disease
30. Individual lacks follow through with diagnostic testing related to health condition
31. Individual does not comply with the prescribed medical treatment (under/over medication etc.) despite a clear understanding of regimen recommendations
32. Individual hoards medication
33. Individual presents with recent unplanned weight loss

**Self-Determinism (4 items)**
34. Individual is not co-operative or willing to accept assistance
35. Individual has displayed self-neglectful behavior at other times in his/her life
36. Individual is reluctant to receive help for daily care
37. Individual neglects personal hygiene

<table>
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<tr>
<th>Scores</th>
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<th>Don't Know</th>
<th>No</th>
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<tbody>
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<tr>
<td>Self-Determinism (4 items)</td>
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<tr>
<td><strong>Add up the total to indicate continuum or severity of self-neglect</strong></td>
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Please mark on line with an X or total score (the number of yes responses)

0……………………………………………..18……………………………………………..37

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Continuum of Self-Neglect

Comments:

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References


Health Service Executive (2014) *Safeguarding Vulnerable Persons at Risk of Abuse National Policies and Procedures* Social Care Division, HSE, Kildare


National Centre for the Protection of Older People, UCD [http://www.ncpop.ie/whatiselderabuse](http://www.ncpop.ie/whatiselderabuse)