

The National Safeguarding Office overview
of the formal submissions received during
the Stakeholder engagement.

HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures Formal Submissions Report

March 2018



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Contents

| | |
|--|----|
| 1.0 Introduction | 2 |
| 2.0 Methodology | 3 |
| 3.0 Results | 3 |
| 3.1 Comment on Current Safeguarding Policy/ Free Forum Open Statements | 8 |
| 3.2 Appropriate Language to Describe Adults at Risk of Abuse Covered by the Policy | 13 |
| 3.3 Who should be covered by a revised policy | 16 |
| 4.0 Principles..... | 18 |
| 4.1 Human Rights..... | 18 |
| 4.2 Person Centeredness | 18 |
| 4.3 Culture | 19 |
| 4.4 Advocacy..... | 20 |
| 4.5 Confidentiality..... | 20 |
| 4.6 Collaboration | 21 |
| 5.0 Considerations on the Revised Definitions of Abuse and Categories of Abuse | 24 |
| 5.1 Additional Considerations..... | 27 |
| 5.2 Physical Abuse..... | 29 |
| 5.3 Sexual Abuse | 30 |
| 5.4 Psychological Abuse | 31 |
| 5.5 Financial Abuse | 32 |
| 5.6 Neglect | 33 |
| 5.7 Institutional Abuse | 34 |
| 5.8 Discriminatory Abuse | 37 |
| 5.9 Proposed Additional Categories of Abuse..... | 37 |
| 6.0 Recognising and Prevention | 38 |
| 7.0 Operational Procedure..... | 42 |
| 8.0 Appropriate Structure/process to manage concerns..... | 45 |
| 9.0 Organisational Role and Responsibility | 46 |
| 9.1 For a Service Manager in Revised Policy..... | 46 |
| 9.2 For Front Line Staff in the Revised Policy | 48 |
| 9.3 For Designated Officers (D.O.s) in the Revised Policy..... | 50 |
| 9.4 For Safeguarding and Protection Teams in the Revised Policy..... | 51 |
| 10.0 Final Comment..... | 54 |
| 11.0 References | 59 |

1.0 Introduction

The HSE is committed to safeguarding people who may be vulnerable from abuse. The HSE launched its safeguarding policy - “**Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures**”¹ in December, 2014 which is now subject to a review process. The policy has been operational in all CHO areas since 2015 and key operational strengths, as well as challenges, have emerged. The terms of reference for this review covers all aspects of the current policy and its operation, including scope, prevention, definitions and procedural systems.

The Review Development Group was established in January 2017 and comprises of membership across the various sectors involved in adult safeguarding. A key component of the work of the Review Development Group is to consult widely both on the current safeguarding system, in addition to giving due consideration to future models of service delivery.

This review has been undertaken on a phased basis. The first phase concentrated on how the policy is experienced and working in practice for current users of the policy. This was completed in mid-2017. The second phase called for formal written submissions from interested parties and stake holders considering any views on the proposed revision of the current policy. The second phase also incorporated face to face stakeholder consultation via focus groups meetings for more specific feedback and consultation.

This report considers the information gathered from the formal submissions of phase 2 of the review, with emphasis on the key findings and themes. A separate report will issue relating to direct stakeholder engagement via the focus group process.

2.0 Methodology

The HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures Review request for formal written submissions was issued in September 2017 by the National Safeguarding Office, on behalf of the Review Development Group.

Phase 2 incorporated a formal submission request using survey monkey. In order to effectively collect feedback, the HSE Review Development Group prepared a standard template for individuals and organisations to provide their submissions. The use of this template was at the individual's discretion. Participants were also invited to submit handwritten submissions which were digitised for analytics by the National Safeguarding Office.

Survey monkey Survey Software was used to compile the submissions, allowing respondents to complete their submissions online. The initial closing date was set for the Friday September 29th was subsequently extended to the 20th October 2017.

3.0 Results

There were 75 individual submissions made during the reporting period, 69 of these were issued through the online platform with a further 6 issued directly to the National Safeguarding Office. Organisational submissions were predominantly through the online platform (n=75) with a further 23 issued directly (Fig 1). The majority of submissions categorised "organisational" included individual organisations and umbrella organisations. These represented regulatory, voluntary private and public service provision with a listing provided in table 1.

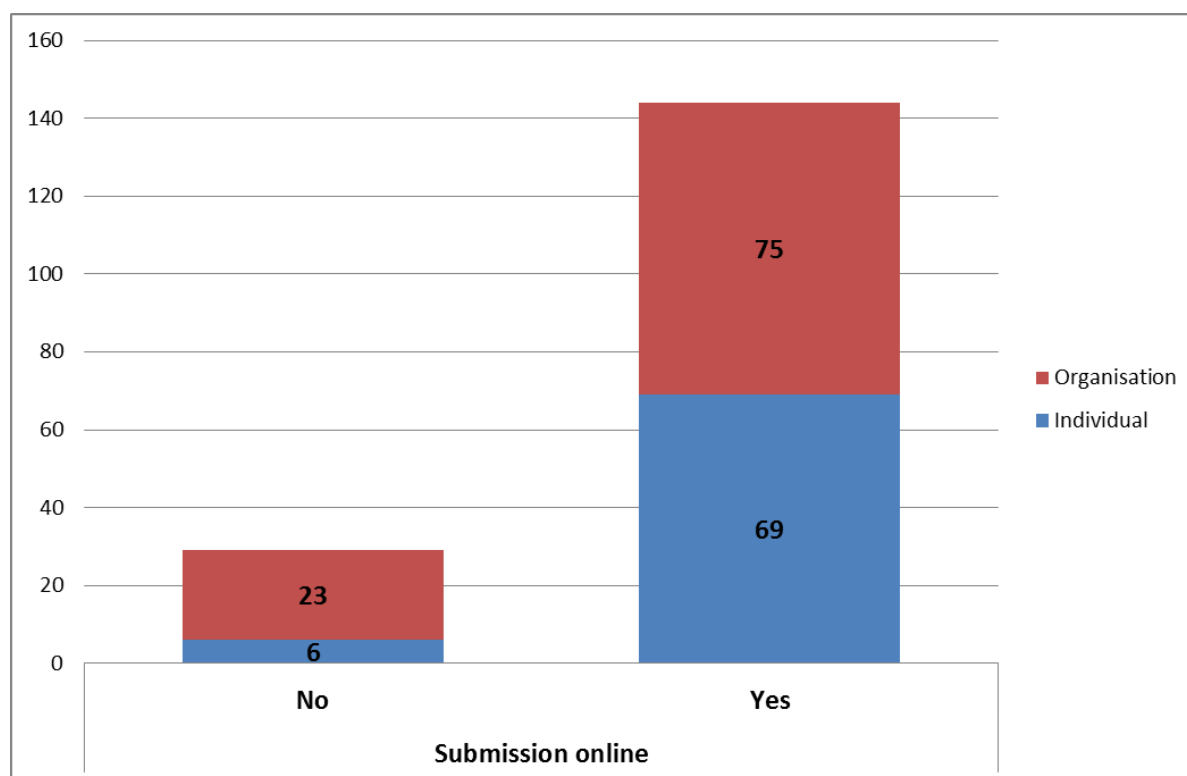


Fig 1: Profile of All Submissions- Individual and Organisation by Method of Submission

Table 1: Summary of Organisational Submissions

| Sectors/Stakeholder Grouping | Number |
|--|--------|
| HSE Sectors | |
| HSE non specific | 10 |
| HSE- Mental health Services | 3 |
| Safeguarding Team - CHO 3 | 1 |
| Office of the Nursing and Midwifery Services Director | 1 |
| Social Work Department in CHO6. | 1 |
| Clonskeagh Community Nursing Unit Willow Day Unit | 1 |
| CI Tobar - Donegal Community Inclusion Training Services | 1 |
| Safeguarding Team CHO 1 | 1 |
| Adult Social Work Service St Conal's Hospital, Letterkenny | 1 |
| Primary Care Social Work, Cavan | 1 |
| Claremont Residential and Community Services For Older Persons | 1 |
| Public Health Nursing | 1 |
| Regional Chief Environmental Health Officer Dublin North East | 1 |

| | |
|---|---|
| HSE Patient's Private Property Central Unit | 1 |
| Safeguarding Committee, CHO 5, HSE | 1 |
| HSE PC Social Work | 1 |
| Safeguarding Team CHO 4 | 1 |
| HSE South, CHO 5, District Hosp. Gorey | 1 |
| Safeguarding Team CHO7 | 1 |
| HSE West Cork Mental Health Services | 1 |
| Social Work in Primary Care counties (Laois, Offaly, Longford and Westmeath) | 1 |
| National Ambulance Service | 1 |
| National Primary Care Social Work Manager's Group, HSE | 1 |
| Safeguarding Principal Social Workers HSE | 1 |
| Residential and Nursing Facilities | |
| Raheny Community Nursing Unit | 1 |
| St. Attractas Nursing Home | 1 |
| St Mary's Home, Pembroke Park, Ballsbridge, Dublin 4 | 1 |
| Boyne Valley Nursing Home | 1 |
| Padre Pio rest Home | 1 |
| Glenaulin Nursing Home | 1 |
| St James's Hospital-Hollybrook Lodge Residential care unit. | 1 |
| Glendonagh Nursing Home | 1 |
| St. Anthony's Nursing Home | 1 |
| Marymount Hospital and Hospice | 1 |
| Ashlawn House Nursing Home | 1 |
| Mystical Rose Nursing Home | 1 |
| Nua Healthcare | 1 |
| Orwell Healthcare | 1 |
| National Federation of Voluntary Bodies and Intellectual Disability Sector | |
| WALK | 3 |
| SOS Kilkenny | 1 |
| Brothers of Charity Services Ireland | 1 |
| Clann Mór | 1 |
| St Michaels House | 1 |
| National Federation of Voluntary Bodies | 1 |
| Prosper Fingal | 1 |
| Special Olympics Ireland | 1 |
| Kerry Parents and Friends Association | 1 |
| St. Joseph's Foundation, Charleville | 1 |
| Home and Day Care Service | |
| Right at Home Galway | 1 |

| | |
|---|-----------|
| Caremark | 1 |
| Sandra Cooney's Home Care | 1 |
| North Dublin Home Care | 1 |
| RHS Home Care | 1 |
| Alzheimer Society of Ireland | 1 |
| Little Angels Association | 1 |
| Physical and Sensory Disability Sector | |
| County Roscommon Disability Support Group CLG. | 1 |
| Respond Support Nethercross DCC | 1 |
| Enable Ireland Services | 3 |
| Irish Wheelchair Association | 1 |
| Cork Centre for Independent Living CLG | 1 |
| Central Remedial Clinic | 1 |
| NCBI | 1 |
| Deafhear | 1 |
| Anne Sullivan Centre | 1 |
| Tusla | |
| Tusla, Child and Family Agency | 1 |
| Tusla West Roscommon | 1 |
| Acute sector and Medical bodies | |
| National Rehabilitation Hospital | 1 |
| Mater Hospital Social Work Dept | 1 |
| College of Psychiatrists of Ireland | 1 |
| College of Psychiatrists of Ireland | 1 |
| Regulator | |
| HIQA | 1 |
| NMBI - Nursing and Midwifery Board of Ireland | 1 |
| Advocacy Organisations | |
| Sage | 1 |
| National Advocacy Service | 1 |
| Trade Union and Professional Bodies | |
| Social Workers in Disability Special Interest Group in the IASW | 1 |
| IASW | 1 |
| IMPACT | 1 |
| Medical Social Work Forum | 1 |
| Others | |
| Novas | 1 |
| Dublin City Council | 1 |
| National Safeguarding Committee | 1 |
| Grand Total | 98 |

The profile of staff indicated that a high proportion of submissions were made by management (39%) followed by social worker (26%)

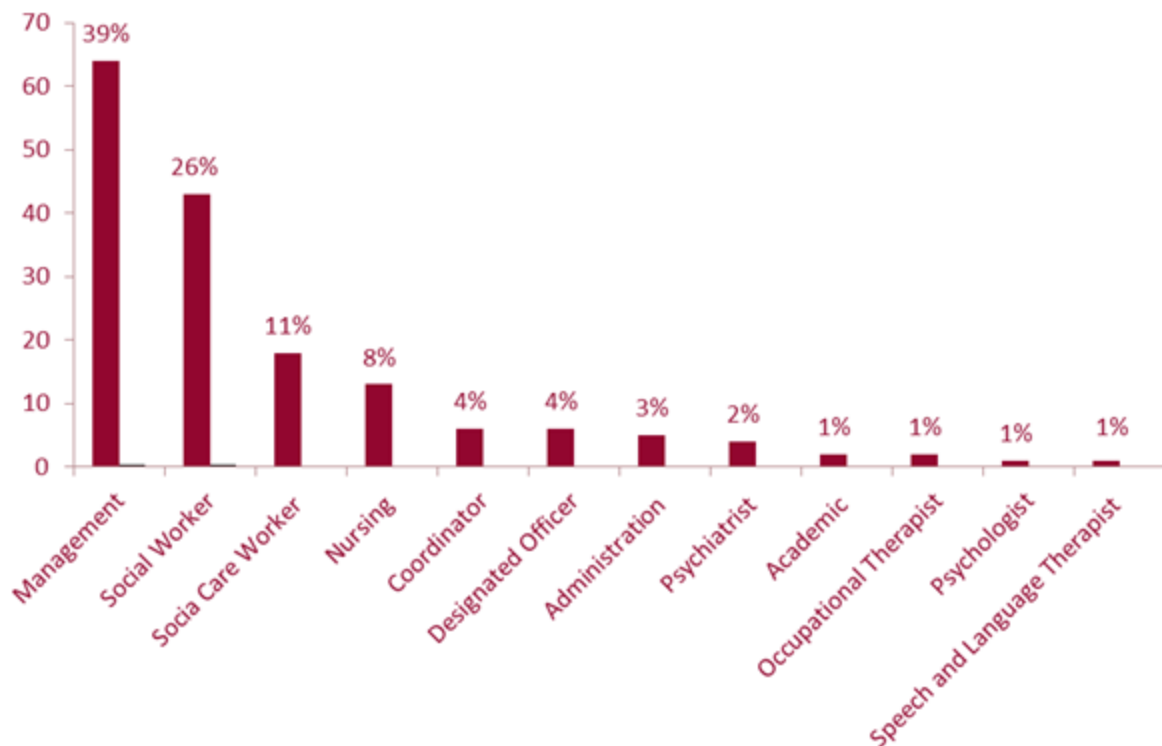


Fig 2: Profile of all Respondents by Occupational Role

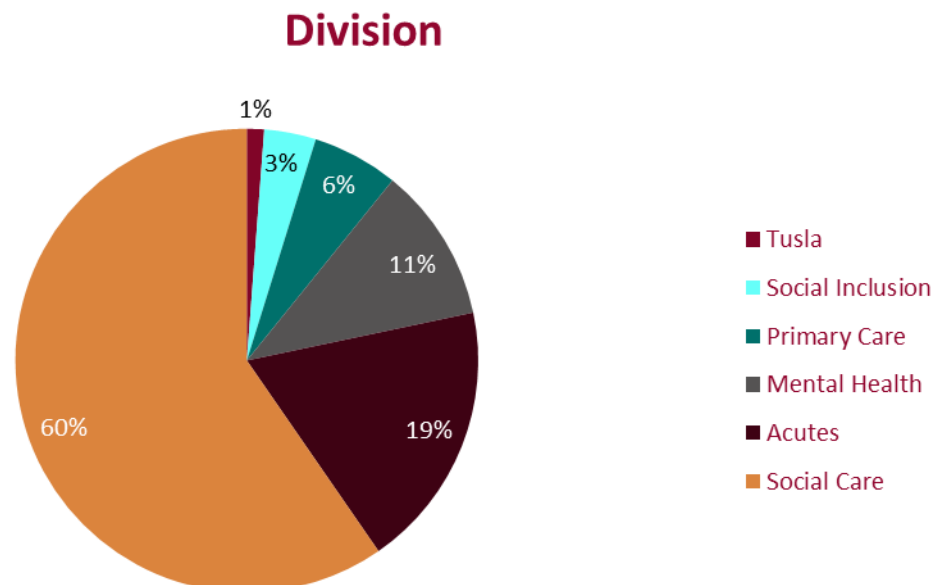


Fig 3 Profile of Divisions for all submissions (organisation and individual)

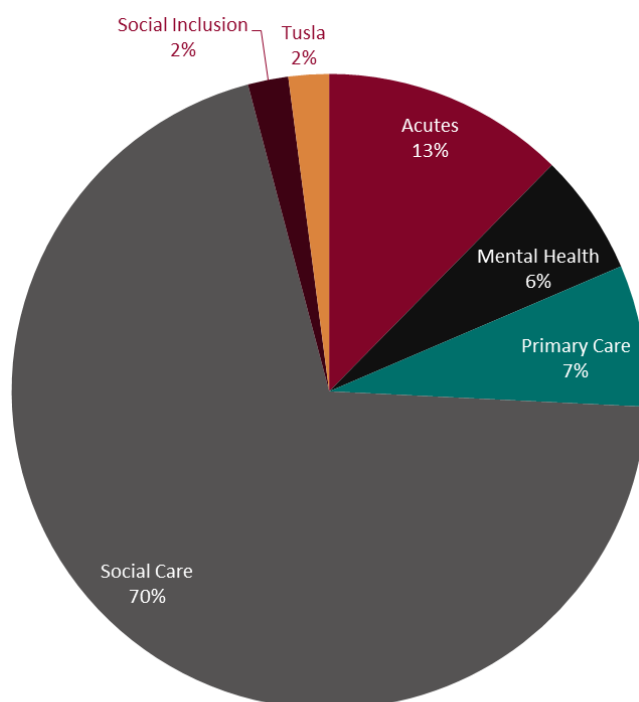


Fig 4: Profile of HSE Submissions

3.1 Comment on Current Safeguarding Policy/ Free Forum Open Statements

General Commentary

From the outset contributors were asked to provide some comments on the current safeguarding policy in the form of an opening statement. In these contributions many felt that **service users are safer** as a result of the safeguarding policy implementation, indeed it is welcomed in terms of its introduction of standardised responses, forms and timescales thus ultimately leading to increasing focus on accountability.

However, challenges both in its implementation and scope were highlighted as shown by the following submission;

“The issues for everyday practice are how to ensure this is embraced in spirit and embedded in organisations and among professionals. I see progress in everyday practice on a continuum –from blatant disregard for the process, to reporting some but not all issues, to striving for, and achieving best practice in safeguarding. It is my view that it is early days for this policy and the review needs to build on this at this

point. If the review is to achieve across the board improvements in safeguarding it needs to ensure that all those involved are aware of, clear about and committed to safeguarding. At this stage there is still work to be done and we think that giving organisations the autonomy to threshold cases at this point is too early.”

Lack of National Health Position and Primary Legislation

It was also felt by a number of submissions that there should be a national policy direction and lead by the Department of Health, rather than just a HSE Policy, with due consideration to the inclusion of the private health sector providers. This national process has commenced by the Department of Health however, it will not be completed in the timeframe for the launch of the revised adult safeguarding policy. There was a strong sentiment expressed that the introduction of safeguarding legislation, which prioritise the human rights of vulnerable people, is necessary to more effectively protect at risk people in Irish society.

Need for a Wider Scope and HSE Cross Divisional Policy

The submissions highlighted a strong requirement for safeguarding to be a cross divisional policy within the HSE and not just operate within the social care division with particular mention of mental health, acute services and primary care. Other submissions noted the need to be inclusive of domestic violence and addiction contexts. Some organisations felt strongly that adult safeguarding should exist, as a service independent of the HSE, and advocated the requirement for a statutory framework. Concern was also noted with the current format in that there has been a lack of consistency in the manner in which service users, who engage with multiple divisions, have had their safeguarding concerns managed.

Requirement for Stronger Interagency Collaboration

The submissions noted a need for stronger and clearer interagency collaboration.

Specifically there needs to be more information provided on engagement with An Garda Síochána in terms of appropriate referrals and the legislation,

“.....without adequate legislation to back up any policy, how can social work safeguard. This policy in effect is hoping that those that abuse will just stop without proper policy and legislative input.”

Submissions from the voluntary sector raised concerns that the current position does not provide a legal basis for many of the concerns received by voluntary organisations which create challenges when trying to comply with other legal considerations such as employment law, data protection and criminal law thus creating dilemmas.

Requirement to Rationalise Procedures

The current policy has been found to be **procedurally heavy** by a number of parties making submissions especially by residential services. This has implications in terms of the administrative demands in dealing with a concern. Some contributors felt that the workload of the Safeguarding and Protection Teams have been too great, which has led to their being unable to provide timely responses to preliminary screenings.

Revised Policy to Consider Reporting Threshold

While some contributors felt that it is premature to introduce reporting thresholds “*we need our staff to over rather than under report*”, the majority of submissions received, especially from residential and intellectual disability sectors, were in favour of their introduction. In this context HSE and HSE funded services would still operate a zero tolerance approach to abuse whilst applying professional judgement (i.e. reporting threshold), in notifying and engaging with the Safeguarding and Protection Teams. The Safeguarding Principal Social Workers noted in their submission that, “safeguarding is yet in its infancy in Ireland and given this, zero tolerance must remain as the position for the foreseeable future in spite of the literature noting a trend away from this perspective in other jurisdictions.”

Peer to Peer Safeguarding Concerns

A number of organisations and submissions question the no tolerance principle when it comes **to peer to peer safeguarding concerns**, proposing that there should be clinical judgement and a threshold present. It has been suggested that cognisance should be taken of intent, impact and context in relation to the definition of an abusive interaction. It was also suggested that there is discrimination, within the current process with staff afforded greater protection within the process than Service users. Other submissions differed highlighting the risk of declassifying/minimising such concerns as non-abuse.

Safeguarding Documentation Needs to be Rationalisation

From a formatting point of view contributors suggested that this document needs to be more concise with a greater provision of flowcharts for ease of application. Leading on from that is the requirement for an overall guidance document that would cover the rights of the alleged person causing concern, interagency working, legal information obligations, over-riding consent and peer to peer interaction.

Position of Self Neglect

There was a strong sentiment expressed that self-neglect needs an appropriate home-and it is not sufficient to include it as a subsection within the safeguarding policy. Some submissions felt that it needs to be stand- alone as a separate policy whilst other argued for integration into the revised policy. The Safeguarding Principal Social Workers noted that Community Health Organisations need to carefully consider their response to self neglect and to which safeguarding model fits local context and deployment of resources.

Training and Continuous Professional Development

Training associated with the policy emerged as a key theme both in terms of its content and its availability. It is evident from the responses that despite the level of training that have been provided since the introduction of the policy, the demand continues to exceed the supply. This is evident from both within social care, in other HSE divisions, funded agencies and the private sector. Additionally, training in the management of self-neglect was also requested. Submissions noted that training needs to permeate into all levels of the organisation including staff, service user and relatives so that all are informed and empowered to act, if witness or involved in any abuse situation. Leading on from this is the requirement for the training materials to be updated and be more comprehensive.

Capacity and Decision Making

A strong view emerged from the submission that the revised policy needs to consider clients who have diminished capacity more comprehensively. There needs to be guidance both on the assessment of capacity, what assessment tool is recommended and the suitable professional to complete such an assessment. The

question of capacity and the Capacity Act² is a recurring theme and the urgent education of all HSE staff and the community is essential.

Resource capacity

Key to the success of any policy is **resourcing**. Contributors felt even though “*the current policy is very positive for residents and service users in the main and supports a person centred delivery of residential care services*” and that it “*provides some assurance to parents, carers and other parties that the HSE takes reasonable steps to manage risks and keep vulnerable adults safe,*” without appropriate resources to implementation care plans it is seriously compromised.

Access to social workers who will support those working with vulnerable persons is vital to its success and many respondents reporting this as an issue. Additionally, in terms of a manageable workload there needs to be meaningful timeframes for communication back from the teams. The current policy and associated procedures is orientated towards the service setting and it is felt that there needs to be greater clarity in relation to the management of safeguarding concerns in the community. The Policy states that Safeguarding is “Everybody’s Responsibility” yet there is a strong sentiment expressed that in reality, this is not happening, and needs to be addressed proactively from a resource management point of view.

Service Improvements

Priority areas for improvement are linked to implementation, oversight and corporate governance. The importance of all organisations being committed to ensuring that all staff are subject to **Garda Siochana vetting**.

Some additional strength identified:

On an overall positive note the National Federation of Voluntary Bodies identified a number of positive developments arising from the introduction of the Policy including:

- The establishment of the National Safeguarding Office, and the work which it has been engaged in, has brought significant structure and attention to the issue of client protection / welfare.
- The adoption of a single consistent approach by all Service Providers to safeguarding is a very positive development.

- The involvement of the HSE in safeguarding is welcome – prior to the introduction of the policy safeguarding was seen primarily as being the responsibility of Service Providers.
- The new processes allow for the escalation of matters to the HSE and to advocate on behalf of individuals arising from safeguarding concerns or the actions agreed within their Safeguarding Plan and this is also to be welcomed.
- Establishing a clear individualised Safeguarding Plan is welcomed and provides for greater tracking, follow-up and accountability.

3.2 Appropriate Language to Describe Adults at Risk of Abuse Covered by the Policy

Language and Concepts

A key theme emerging relates to “**restricted in their capacity**” and the fact that the current policy is not explicit in terms of defining capacity, consent or vulnerability. There is a requirement to define what is meant by “restricted in capacity” and that this is in agreement, not in conflict with, the Assisted Decision Making Act. A number of contributors recommended changing the term capacity, to “adults who may be restricted in ability.” Due consideration should be given to the format of the Criminal Law (Sexual Offences) Act 2017³ which incorporates the functional test for capacity in its definition.

Integral to the capacity debate is how this is assessed. Some contributors felt that it would be important to include further support for agencies to determine if a person is restricted in their capacity due to their intellectual, mental and physical abilities and also due to their circumstances. This definition is a starting point, but it requires a lot more clarity to assist how their capacity is determined, making reference to a person's ability, or inability to make decisions, and how this might place them at risk.

Other contributors felt that the inclusion of capacity excludes individuals who are vulnerable and experiencing abuse, who do not have capacity issues. Additionally, contributors felt that the definition needs to allow for people with disabilities, who have full decision making capacity, who **do not want to make a report** to HSE and/or the Gardai to have that right.

Many submissions have expressed dissatisfaction with the **term vulnerable adult** feeling that it is contrary to the concepts of “independence, citizenship, and self-direction” with possible alternative wording including people needing supports or vulnerable period within people’s lives. In the No Secrets Review Consultation (UK)⁴ The Law Commission 2011 (UK)⁵ indicated that 90% of respondents wanted the term Vulnerable Adult changed to ‘Adult at Risk’ some of the rationale was that the term “vulnerable” places the cause of abuse on the victim’s vulnerability rather than the person causing the concern (Adult Services Report 41 SCIE Prevention in Safeguarding p5)⁶

In contrast, organisations such as the ASI are in agreement with the above wording to describe people with dementia, who may be at risk of abuse who are to be covered by this policy. “While the terms ‘vulnerable’ may be perceived by some cohorts as disempowering or stigmatising (Stewart, 2016)⁷, such as by those with physical disabilities, many people with dementia lack capabilities such as self-awareness, reflexivity, experience progressive loss of memory, difficulty in articulating language and reduction in mental capacity, challenges that increase with time.” Furthermore in their submission they outline that Sherwood-Johnson (2012)⁸ identified certain factors when defining abuse as including vulnerability, namely, abuse linked to capacity, membership of assumed vulnerable group, and relationship between perpetrator and victim, with an expectation of trust, all of which impact on people with dementia. The 2017 De-Stress⁹ study of carer well-being undertaken by the ASI, Trinity College and the HRB indicates that 40% of carers experienced mild to moderate burden, defined as stress associated with caring, while 36% experienced moderate to severe levels of burden. This can lead to greater risk of neglect among vulnerable adults with dementia.

The NI Safeguarding Policy¹⁰ uses the terms ‘an adult at risk of harm’ and an ‘adult in need of protection’. This definition of an adult in need of protection goes further to include someone who is ‘unable to protect their own well-being, property, assets, rights or other interests’ and ‘where action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed’.

Advocacy organisations argue that the current language is quite deficit focused and the revised policy would benefit greatly from the use of more strength based

language. *“More positive language, this is empowering that does not reinforce negative stereotypes would be welcome.”* Furthermore more emphasis needs to be placed on the environmental context of vulnerability.

Greater clarity is required to determine who the policy relates to, which is summarised in the following quote,

“The definition of disability is unclear. It is unclear if mild intellectual disability is included. It is unclear if all forms of disability are included under the policy. It is unclear if members of the public who have a disability but do not attend any service are included.”

Suggested Alternative Wording Provided through Submissions:

- An adult with increased susceptibility to harm or exploitation.
- '.....a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their: Personal characteristics and/or life circumstances. "
- Safeguarding Vulnerable Adults at Risk of abuse should be the title over "persons".
- An adult, dependent on others for assistance...
- a person over the age of 18 whose capacity is limited to understand how to protect himself/ herself against harm or exploitation or to report such harm or exploitation
- expanded definition needed to include vulnerable person who may present risk to others
- "Any adult who has care and support needs and is experiencing/at risk of abuse and unable to protect themselves.”
- Definition needs to be inclusive of those with mild intellectual disabilities and people in receipt of mental health services
- As an adult who may be restricted in capacity, function and reserve to guard himself/herself against harm or exploitation
- Use of the words “undue influence” -more appropriate than exploitation
- A vulnerable adult is a person who experiences abuse in their current situation

- Scottish model : Adult at risk - Section 3(1)¹¹ defines "adults at risk" as adults who:
 1. are unable to safeguard their own well-being, property, rights or other interests;
 2. are at risk of harm; and
 3. because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The presence of a particular condition does not automatically mean an adult is an "adult at risk". Someone could have a disability but be able to safeguard their well-being etc. It is important to stress that all three elements of this definition must be met. It is the whole of an adult's particular circumstances which can combine to make them more vulnerable to harm than others.

- Many vulnerable people have capacity, but fear taking action as the situation may become more severe. The current definition needs to look at the possibility of including the word "fear", in relation to taking action or reporting exploitation.

3.3 Who should be covered by a revised policy

There was no consistent response regarding who should be covered by the policy, which replicates the international experience as documented in the Rapid Realist Review conducted by Donnelly et al 2017¹². The responses within the submissions documented inclusion criteria ranging from all those with care and support needs, to all adults at risk of abuse, to all adults at risk of harm.

Key considerations mentioned included

- Due consideration for people in the community not on a HSE care plan
- Risks to family care givers- as they *"often suffer intentional and unintentional harm from care recipients"*
- Unique challenges that are faced when a service user resides at home, in comparison to a residential service, where there is a huge level of oversight

There was strong support for the more inclusive adult protection model which encompasses more than the health portfolio, however at this time-point this is

aspiration as its implementation is dependent on, and subject to, appropriate legislation.

Consideration of the terms **harm verses abuse** is the critical juncture in decisions on the future development of the service. A number of submissions argue for a move towards harm, which in order to be successfully implemented, requires a high level of professional resourcing, interagency data sharing and primary legislation which heretofore have been identified as issues. Those with addiction issues, and homeless individuals were mentioned in particular and those adults that *“who have full capacity but are susceptible to being bullied, harassed, exploited, mistreated or unduly influenced including those in receipt of or being denied access to HSE services.”*

“ It is important that we get this right as some disability services do not consider those with a mild learning disability to be included in there service responsibility even where they are clearly vulnerable and have experienced significant abuse. Rather they are at the mercy of an insufficiently developed Primary Care Structure. “

There was some concern expressed by mental health professionals as to how self-injurious / self-harm and suicidal ideation comes into play within safeguarding concerns.

All adults have the possibility of being ‘vulnerable’ at some point over their lifetime. Specific groups identified who potentially could come under the Policy include the following:

- Adults who cannot take appropriate legal measures to protect themselves in abusive situations
- Adults who have been determined to lack capacity at a particular point in time;
- Adults at home with no alternative placement and no law to remove them;
- Adults who experience domestic violence;
- Adults with mental health issues;
- Adults with various forms of addiction;
- Adults who are homeless and those with a history of abuse.

In the development of any future service many contributors have advocated for the provision of welfare teams to run alongside safeguarding teams to provide appropriate supports as necessary.

4.0 Principles

Many contributors felt that the principles outlined in the policy were comprehensive, however there were some recommendations made that are included in the appropriate subheadings below. Some agencies recommended that practical examples should be given in relation to each of the principles to allow for greater understanding of what the above means in practice. This should include skills, standards and competences.

4.1 Human Rights

HIQA suggested that the following subheadings should be included under human rights, privacy, dignity, respect, autonomy and fairness.

The Alzheimer's Society of Ireland has developed a Charter of Rights in 2016¹³ for people with dementia, which incorporates a PANEL approach, emphasising principles of **p**articipation, **a**ccountability, **n**on-discrimination, **e**mpowerment, and **l**egality.

As an organisation they felt that, *“A human rights based approach to safeguarding is crucial as it places the individual at the centre of the process. This policy should operate more closely within principles of human rights. If Ireland is to practice human rights based approach to safeguarding it needs to move from the current model of ‘best interests’ to a model that treats the individual as central to the process.”*

4.2 Person Centeredness

There were many contributions on the importance of person centeredness, as it is the basis of the work that we do, and “this culture should be promoted at every opportunity by actions rather than by words”.

Some contributors felt that the prescriptive nature of the current policy is challenging in terms of the implementation of person centeredness and should be considered in the review.

One submission noted:

“I do feel that the service user is at risk of not having their voices properly heard in the process - we need to be able to spend time supporting services in the process and this can be very challenging”

Some submissions noted that this section of the policy should have more details in relation to a person centred framework, outlining the prerequisites, or should at least reference same, so as to direct services to guiding principles.

4.3 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 of the way things are done around here”. (Office of the Ombudsman, Complaints and Complaint Handling¹⁴).

For safeguarding to be successful individuals receiving support from health and social care services will need a safe environment that feels personalised, including person centred care and support, and positive social interactions during care. This positive culture needs to be lived and practiced by all, so that a “no tolerance” culture becomes the norm. In essence *“the culture of person centeredness should be promoted at every opportunity by action rather than by word.”* The culture of all the above items needs to be lived and practised by all HSE employees and associated workers/volunteers to the extent that a 'no tolerance' culture becomes the norm.

It was suggested that 'respect for all' and “user friendly language to state the standard and to identify when that standard is not met.”

A number of submissions noted that resource implications of appropriate safeguarding plans is integral in improving the overall safeguarding experience for both staff and service user.

4.4 Advocacy

Advocacy, in all its forms, acts to empower people by enabling them to assert their rights, will and preferences make choices and decisions and maximise their capacity thereby acting as a safeguard. Service providers and professionals may sometimes experience a conflict between advocacy and their primary role in an organisation. Similarly, families can be compromised in terms of their ability to make informed, objective decisions in the best interest of the client and, for this reason, many feel that an independent advocacy service is usually seen as '*the better option*'.

Contributors felt that in light of the Assisted Decision Making Act¹⁵ the requirement for independent advocates was never clearer, serving to provide for supported decision-making, thus offering a less restrictive alternative to the current practice of wardship and/or other forms of substitute decision-making. However, it is important to emphasise that it is the person's decision to engage an advocate, and that they cannot be 'appointed' on a person's behalf against their wishes.

For Independent representative advocacy it was argued in the submissions that it is essential that these advocates have access to relevant documentation and information (including safeguarding screenings and plans), as is relevant to the safeguarding issue and in keeping with the person's wishes, to be best placed to represent the person. Currently, services sometimes refuse to share plans with advocates, which can significantly affect the advocate's ability to be best placed to work with the person.

Submissions also referenced that there should be specific mention of the Department of Health work in developing a Patient Safety Complaints and Advocacy Policy. This aims to provide a policy to improve how the health service responds to complaints, and advance on the Programme for Partnership Government (2016)¹⁶ commitment to establish a national patient advocacy service.

4.5 Confidentiality

The General Data Protection Regulation, due for implementation in May 2018, was pivotal in the submissions made on the topic of confidentiality. The need for greater guidance on the implications, and the requirements from a safeguarding perspective, within the revised policy will be key. Given the sensitivity of the information being

collated due consideration needs to be given to each of the stages outlined in the document “The GDPR and You” summarised in fig 5.

Concerns were raised that currently the principles are not always being implemented with the following examples provided :

- A persons human rights might be impinged upon, by being named as a person causing concern, in peer on peer incidents
- Confidentiality not being respected
- Sharing of information without consent
- Collaboration not always happening between the Service Providers and the CHO Safeguarding and Protection Teams

A number of submissions stated that the limits of confidentiality need to be clearly stated within the policy so there is no ambiguity in interpretation.

4.6 Collaboration

Many submissions argued that inter agency collaboration needs to be explicitly expanded to include agencies outside the HSE e.g. An Garda Siochana, voluntary agencies, housing and financial institutions. Safeguarding is not just a health issue it permeates into all sections of society. This is reflective of the collaborative working of the National Safeguarding Committee and indeed, in the newly established regional safeguarding committees. The legislative basis for collaborative working is addressed in the proposed Safeguarding Bill and the requirement for same, to ensure collaboration occurs was documented in submissions.



<https://www.dataprotection.ie/docimages/documents/The%20GDPR%20and%20You.pdf>

Fig 5 Summary on the Implications of the GDPR from the Data Protection Commissioner

Additional Factors to Consider

1. **Consent:** There needs to be further clarification with regards to a person's right to withhold consent to the sharing of information, where capacity has not yet been established. Contributors felt that adequate reference to consent needs to be included and there are conflicts within the current policy, thus reducing the autonomy of service users. Reference was made to the fact that the Elder Abuse Policy¹⁷ included the right to self-determination and this needs to be to the fore in this policy also. Consideration of the Northern Ireland Policy¹⁸ and the consent drive approach was recommended
2. **Autonomy and Dignity** are guiding principles of the Assisted Decision Making Act and the ethos of this should be followed within the safeguarding policy. Inclusiveness of the person is fundamental – i.e. ensuring the person is actively involved in the process. Some submissions noted that there needs to be stronger measures to ensure the voice of service is heard in the adult safeguarding process.
3. **Right to Enablement and Reablement-** the revised policy should promote wellbeing and independent of service users.
4. **Referenced material:** *“The principles have been taken from the HIQA standards however it might be equally useful to have some references to other documents i.e. New Directions¹⁹ because this policy needs to be relevant to all services not just residential.”*
5. The inclusion of '**Compassion**' as a core principle would be welcome. 'Compassion' demonstrates wanting to help, reach out and support and represents the human response that people who experience or are at risk of harm, exploitation or abuse often require.
6. **Entitlement to Assessment and Services** Some submissions made the point that any policy of this nature, needs to be underpinned by a principle of greater rights and access to assessment / direct service provision where there is a risk of abuse.

5.0 Considerations on the Revised Definitions of Abuse and Categories of Abuse

Definitions of abuse are a core element both in the development of policy and to creating understanding in wider society. Therefore, this is a fundamental part of the revised adult safeguarding policy. Abuse is a strong and emotive term. Whether or not an action is considered to be abusive is determined by the official definitions set out in policies and legislation, and if the necessary criteria are met then this should trigger a particular response. There is no primary adult safeguarding legislation currently in the Republic of Ireland. In the absence of such legislation the definition employed by the HSE, as the primary provider and commissioner of health services as well as the relevant Regulators (HIQA and Mental Health Commission), will be sought and utilised.

Singular or repeated Acts

Abuse is often understood as repeated acts however a number of submissions highlighted that the definition needs to continue to include the term **single acts** which can be significant for example, in relation to assault.

Issue of “undue influence”

A number of submissions recommended that the definitions should include exploitation, mistreatment, and harassment, inclusive of undue **influence** of the vulnerable person, from whatever source including family, staff or fellow service users. Due consideration needs to be afforded to bodily integrity, exploitation, control and manipulation in the definition. This issue should be kept under review to cover emerging trends of abuse.

Expectation of “trust”

Some submissions recommended the incorporation of the elder abuse policy definition stating that abuse can be defined as *"a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an **expectation of trust** which causes harm or distress to an older person"*. Elder abuse can take various forms such as financial, physical, psychological and sexual. It can also be the result of intentional or unintentional neglect. The trust relationship was noted as

being a very important part of the definition within elder abuse and many submissions felt that it was important to capture this dynamic in the revised policy.

Inclusion and Position of Self Neglect

The current policy addresses 'self-neglect' as an attached chapter, in relation to a process to respond to extreme self-neglect. It is not within the formal definition of abuse and the current adult safeguarding procedure. The current safeguarding policy considers vulnerable persons at risk of abuse rather than at risk of harm. The absence of "**self-neglect**" and indeed '**self-harm**' is noticeable in the definitions and the Review Development Groups needs to carefully consider how responses to such concerns, could be appropriately aligned to an adult safeguarding process and procedure. Some submissions advocated for an adult at risk of harm scope, rather than at risk of abuse, and for the inclusion of self-neglect within adult safeguarding procedures. Strong interagency collaboration processes are required to manage such cases. Self-neglect has a clear health service response component however an expanded scope into social exclusion areas, with regard to an adult at risk of harm procedure, would be problematic for the HSE, without clear legislative and mandated responsibility into areas such as domestic violence and housing provision.

Application of Thresholds

The definitions as they are contained within the current policy, do not allow for or consider any threshold application, either at the screening process, or at the reporting point to the safeguarding team. A number of submissions noted that this has led to over reporting of lower level concerns and interactions, especially between service users. Some submissions noted that behaviour support needs, actual diagnosis, cognitive ability, impact and intention to harm, needs to be taken into account in a threshold application. A critique of the current policy is that it does not allow for professional judgement and proportionality. It was also raised that there can be an unintended consequence of disregarding the person's rights around consent, to share information and autonomy, to make what might be considered an unwise decision.

Some of the submission recommended that the Designated Officer needs to make a professional judgement whether or not the concern is of a safeguarding nature, has

reasonable grounds and therefore warrants notification to the Safeguarding and Protection Team. It has been recommended by a number of submissions that this application of professional judgement and proportionality should be clearly stated and documented in the revised policy. Other submissions urged caution on applying a definition, or reporting threshold, and cited concerns that service improvements may be impacted and some services/ providers may not be ready or able to hold and properly manage this responsibility.

Understanding Abusive Interactions between Service Users

A number of submission felt that there needs to be an acknowledgement that abuse does occur between service-users and should not be routinely, or inappropriately, declassified as behaviour support issues. However, a number of other submissions noted that in certain contexts, such as some service users with dementia it can be unintentional or non-deliberate, as the service-user may lack self-awareness, intent and reflexivity. It was noted that whilst abuse may not be the intention of peer to peer interactions, it may be facilitated by staff or management's failure to protect and ensure the safety of services users from their peers. This failure by staff and management could constitute organisational abuse.

Based on the feedback received it is evident that the policy needs to recognise that patterns of abuse exist within organisations, and by individuals, and highlighted the need to recognise and assess this. Repeated and unresolved incidents of service users abusing each other, needs to be viewed in light of whether or not the organisation is taking adequate measures to protect them.

Continued use of term “vulnerable person” in application of definitions and categories of abuse

The use of the term vulnerable person has been raised and questioned. Many of the review submissions and the UCD commissioned research findings highlight that this term has a value judgement and may give the impression that there is something 'faulty' with the person, thus making them vulnerable. Whereas, vulnerability is situation specific the crucial issue is one's capacity to prevent abuse, stay safe, and/or report incidents of abuse.

5.1 Additional Considerations

- **Legal context and Criminal Definition of Abuse**

Some submissions noted the need to consider whether the definitions reflect legal understanding or are they based on social definitions. Need to be mindful of legal developments such as the expected use of the functional test of capacity under the Assisted Decision Making Act. Greater clarity and working protocols are needed with An Gardaí Síochána and criminal justice system which should clarify what constitutes criminal acts under legislation. Also noted is the requirement to develop a protocol to support the management of vulnerable individuals, who may be perpetrators of child sexual abuse or sexual assault, with a requirement for strong interagency collaboration in this area.

- **Use of Organisational Abuse Category.**

The international trend and research is now focused on term organisational abuse rather than term institutional abuse. Research reflects the need to focus more on culture, patterns of behaviour and organisational responses rather than buildings or locations of services. Some submissions noted the need to leave in this category *"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."* Some of the submissions argued that inadequate access to resources for persons with complex care needs by the HSE / Service Providers could constitute a form of organisational abuse. Organisational abuse by definition includes any act or failure to act, which results in a person being harmed physically, sexually, emotionally, financially, psychologically, organisational.

- **Natural Justice, Right of Appeal and False Allegations**

Some submissions raised issue of false allegations that are made against a service user and that there needs to be room for appeals. Noted that systems need to be careful not to inappropriately label a staff member, or service user, who is a person of concern as an alleged "perpetrator" or an alleged "abuser", where there is no avenue to challenge this term.

- **Improved engagement with Advocacy Services**

Promote engagement with advocacy services so that we ensure that consumer voice is heard when screening or assessing safeguarding concerns.

- **Clarity, Presentation and structure in the revised policy document**

As an overall point regarding the abuse categories listed in the next section, there was a strong consensus from submissions that each category needs to be defined more comprehensively in the body of the document. Further defining the various types of abuse would help those providing care to be more aware, and have an in-depth understanding of, what each type of abuse means. While some examples are included in the appendix of the current policy document, they should be highlighted earlier in the document. Additionally there should be a section on indicators and then examples of the behaviour.

The section on definitions needs to include the following:

- a) Definition of abuse
- b) Examples of this abuse
- c) Indicators of this abuse

Specific reference is made in the submissions to the following documents which should be considered in the revised document

1. Protecting adults at risk: Good practice guide' **Social Care Institute of Excellence 2012**

was referenced as it has a number of definitions recorded in literature regarding Adult Safeguarding and Abuse

2. Children First
3. No Secrets
4. Northern Ireland Procedures for Adult Safeguarding
5. NCPOP

Requirement for information to be available in easy to read format and develop consumer friendly versions was strongly advocated. In its presentation there need to be have better consumer friendly versions which are intellectually accessible to all. It is recommended having an easy read version, social media access and audio version

5.2 Physical Abuse

Suggested inclusions in revised definition:

1. *"Physical abuse results in actual or potential physical harm from an interaction or lack of interaction with an individual. It may be a single or a repeated incident."* Child Protection and Welfare Handbook
2. Physical abuse includes all forms of tactile contact which results in harm to a person.
3. *"An intentional act causing injury or trauma to another person by way of bodily contact"*
4. Physical abuse which results in actual or potential physical harm from an interaction or lack of interaction.

Key Considerations in revised definition, descriptors and indicators:

- Inclusion of inappropriate actions, misuse of incontinence wear, forced feeding, rough handling, unwarranted physical pressure (gripping, squeezing) shaking, pinching, throwing, burning or scalding or otherwise causing physical harm. Also include confinement in a area e.g. being locked in the home
- Provide more examples for ease of understanding. However qualify the list by saying that these are examples and the list is not exhaustive of all types of physical abuse
- Include deprivation of liberty examples
- Many of the physical abuse examples provided in the current safeguarding policy are criminal assaults in Common Law and should be defined as such
- Important to include the threat of physical violence

5.3 Sexual Abuse

Suggested inclusions in revised definition:

1. *"Sexual abuse includes rape and sexual assault, or sexual acts to which the person has not consented, or could not consent, or into which he or she was compelled to consent"*
2. Sexual abuse may include physical contact or non contact activities such as
a) looking at or b) being included in the production of sexual images/videos or grooming.
3. *'Abusive acts of a sexual nature include but are not limited to 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, exposure to porn, inappropriate touching and either being made to watch inappropriate sexual material or be made pose for inappropriate sexual positions/filming'*
4. Protecting adults at risk: Good practice guide' SCIE 2012 include:
Examples of behaviour – Non-contact abuse Inappropriate looking sexual photography Indecent exposure Sexual teasing or innuendo Pornography/being forced to watch pornographic films or images , enforced witnessing of sexual acts or sexual media harassment. Examples of behaviour – contact abuse rape or attempted rape, any sexual assault inappropriate touch anywhere, masturbation of either or both persons, penetration or attempted penetration of the vagina, anus or mouth, with or by penis, fingers or other objects Sexual activity that the person lacks the capacity to consent to.

Key Considerations in revised definition, descriptors and indicators:

- Consider threats and inappropriate language intimidation via sexual language- removing the word assault is considered beneficial as its inclusion places an expectation of an extreme event before it is considered abuse
- Consider digital/social media and online sexual abuse/ production of sexual image
- Consider historic abuse

- Ensure grooming is adequately considered
- Provide greater emphasis and clarity on capacity and consent
- Provide greater elaboration on behaviours and defining inappropriate touching, as this provides challenges in congregated settings where there are two residents with diminished capacity and what determines if this interaction constitutes sexual abuse

5.4 Psychological Abuse

Suggested inclusions in revised definition:

1. Psychological abuse is any act or omission by another person or persons which causes mental distress to an individual.
2. Failing to value the individual, abuse of power in which the perpetrator places their opinion/view/judgement as superior to the individual, value judgements, conveying to the individual that they are worthless, unloved, inadequate, a nuisance.
3. Denying the individual the opportunity to express their views in a manner which is comfortable to them, deliberately silencing them or ignoring them or their communications written or spoken, making subjective comment about the way an individual chooses to express themselves, imposing unrealistic expectations on the individual.
4. 'Abusive acts of a psychological nature include, but are not limited to, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks, patronising approaches to care and support for example 'elder speak' or spoken to like a child, intolerance of religious or religious beliefs, intolerance of cultural beliefs, and in the case of married/co-habiting couples enjoy the right to shared and appropriate accommodation.

Key Considerations in revised definition, descriptors and indicators:

- It is suggested by some submission for an application of threshold on emotional abuse - *"The word 'persistent' would be helpful in giving a*

threshold. There should be no threshold for staff or professionals - however between peers or within families there has to be some level of threshold."

- Deprivation of liberty examples need to be included
- Online abuse/social media-" Include risk of abuse via technology --thinking exposure to inappropriate abusive material, video without consent and upload it"
- Co-dependent relationships needs to be considered as a new phenomenon grandparents and grandchildren with addictions
- The carer-person in need of care relationship may be vulnerable to abuse in both directions, neither deliberate but can be very harmful.

5.5 Financial Abuse

Suggested Inclusions in Wording of Revised Definition:

1. *"The illegal or unauthorized use of a person's property, money etc..."*
2. As financial abuse often includes the misuse of pensions and or social welfare benefits e.g. disability allowance, it is proposed that the definition is extended as follows... *"or the misuse or misappropriation of property (including pensions, or others statutory entitlements or benefits"*
3. Financial abuse is any act where a person is deprived of their finances or personal possessions or exploited financially by another person or persons.
4. *"Financial or material abuse has been defined as the unauthorised and improper use of funds, property or any resources of an older person. This may include theft, coercion, fraud, misuse of power of attorney, and also not contributing to household costs where this was previously agreed."* Elder financial abuse definition from the NCPOP is clearer.
http://www.keepcontrol.ie/financialabuse_whatisit
5. Review definition stated in SCIE 2012 and DOH 2000 No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse DOH 2000
6. Financial abuse is any act where a person is deprived of their finances or personal possessions or exploited financially by another person or persons.

Key Considerations for Revised Definition, Descriptors and Indicators

- Include the misuse of pensions and or social welfare benefits
 - Failure to make appropriate financial decisions-in order for a person to avail of Nursing Home Support Scheme: Fair Deal
 - Institutional financial abuse needs to be included
 - Systems/Institutional financial abuse should be recognised and residents in care homes who pay/have service agreements ('Fair Deal') should not be required to pay more for activities/required treatments/therapies.
 - However there should be an insistence that financial abuse must be reported to An Gardaí Siochana and any investigation must be Garda led. Difficulties to date, not related to the definition but rather in the responses available, to prevent a reoccurrence
 - Include refusing to get paid employment, running up debts, use of bank and credit cards without permission
 - Lack of financial transactions in breach of an agents responsibility e.g. not paying bills of a vulnerable adult thus making them a bad debtor is also financial abuse
 - The fact that institutions still have bulk payment systems is not person-centred and could be construed as financial abuse.
- Lack of universal entitlement obliges carers to be involved in the vulnerable person's financial affairs which may be a risk

5.6 Neglect

Suggested Inclusions in Wording of Revised Definition:

1. *"Abusive acts of neglect and acts of omission include, but are not limited to ignoring the person, ignoring the medical or physical care needs, failure to provide access to appropriate health, social activities and care or leisure and educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating"*
2. *"- threshold required for harm to a person act or failure to act causing harm to the person by a person who is responsible for caring for the victim whether employed or has made an agreed or legal commitment to care "*

3. Neglect is where harm is caused because a person's basic health and care needs are not met.
4. *"..Includes ignoring a person's needs- whether stated, obvious or known needs such as medical or physical care needs..."*

Key Considerations in Definition, Indicators and Descriptors

- *"It is important to acknowledge that ignoring need, either physical or medical, can mean knowing that a need exists, but choosing to not address that need, thereby leaving the person at risk of deterioration in health and wellbeing."*
- Recommendation around break up of neglect section into service-led/ institutional neglect and familial/ carer neglect sub-categories
- Neglect also includes not meeting the social, psychological or spiritual needs of the vulnerable person and not addressing environmental factors/adaptations required to adequately meet the needs of the vulnerable person
- Need to make reference to self-neglect linkage to Assisted Decision Making Act
- Some submissions argue that this should include, where the vulnerable person does not have access to, or is not provided with the appropriate supports in the community.
- Some submissions recommended introducing thresholds, as neglect is a feature of poorly resourced households and in families barely coping. Noted that labelling families as neglectful /abusive is a retrograde step and really unhelpful as there is no legal obligation on carers to continue in caring role where they cannot no longer cope or manage with the responsibilities

5.7 Institutional Abuse

Suggested Inclusions in Revised Wording of Definition:

1. *".....it can occur in any congregated setting to include acute care, primary and community care settings, including day care services, transitional/ respite care and long-term residential care for older people and persons with disabilities"*

2. *“.....e.g. where a Service Provider supports a VA in their own apartment (rather than in residential / institutional setting). This is especially important given the positive moves made away from 'congregated settings’”*
3. *“.....routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of individuals.”*
4. Abusive acts of institutional abuse, occurring within foster homes, kinship care homes, residential care and acute settings including nursing homes, acute hospitals and any other in-patient settings, include but are not limited to Mistreatment brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting
 - Rigid routines, poor standards of care and inadequate responses to complex needs
 - Maltreatment through inadequate resources
 - Harm related to poor assessments/placement supports
 - Failure to afford people the opportunity to engage socially and be involved in hobbies/activities that are meaningful to them, which in turn results, in a failure for their psycho-social needs to be met
5. Term is too narrow and should be labelled organisational abuse: *“Organisational or institutional abuse is brought about by poor or inadequate care or support services, or systematic poor practice that affects the whole care setting. It can occur when individuals wishes and needs are sacrificed for the smooth running of a group, service or organisation (Harrow)”*
6. Systematic and repeated failures that are culturally inherent in the organisation – for example a collective failure on the organisation to take appropriate action on safeguarding incidents is organisational abuse (sense.org.uk)
7. Organisational abuse is more than something that takes place within the walls of units / residential homes and hospitals such failures are seen within the community within people’s own homes with services having full knowledge of safeguarding issues and not acting in a responsive way to minimise ongoing abuse. Institutional abuse can be a mind-set.

8. Institutional abuse is not confined to a building. Abuse may be perpetrated by an individual staff member or group of staff embroiled in their own accepted customs, subculture and practice or the accepted customs, subculture and practice of the institution or service. Failure of managers, to address issues of concern, should also be included.

Key Considerations in Relation to the Definition, Indicators and Descriptors

- Home Care and the strict scheduling boundaries driven by the medical model do not always allow for the choice of the individual.
- It can occur in many different settings including small community based residential facilities. Due consideration needs to be given to the new and emerging models of care that can have institutionalised practice cause abuse of vulnerable adults. Add/ alter to include 'organisational abuse' within this category e.g. where a Service Provider supports a vulnerable adult in their own apartment (rather than in residential / institutional setting).
- Reference to decongregation in the following context-“.... *I know of people who have been moved geographically, but still feel and are treated institutionally*”
- Requirement for case examples to challenge historic practice
- HIQA advocate that “*there needs to be a clear focus on accountability. It needs to recognise that the abuse element is where the service provider is failing to protect vulnerable people from safeguarding risks where those individuals are being harmed on a regular basis because of altercations with peers*”
- Parental rights of a Vulnerable Adult should be overtly mentioned here (or under 'discriminatory abuse') i.e. practice of some Tusla Child Protection Teams to immediately look at Care Order proceedings where the new / expectant parents have a disability.
- The issue of inappropriate residential placements for Persons with a Disability (e.g. 30 / 40 year old persons with an ABI being placed in a nursing home) should be overtly referenced as an example of abuse.

- Some submissions believe that this should be expanded to include the poor standards of care which can occur in the community by home care package providers and primary care professionals, both HSE and private.
- It needs to be acknowledged that institutional abuse can also occur when routine and rigidity are allowed take over from a person-centred approach to care. Institutional abuse can occur both in day care and long term care.
- In addition, care practices which become abusive needs to be highlighted more e.g. Mid Staffordshire Hospital, in order that Quality and Patient Safety begin to identify and report these as safeguarding.
- Professional misconduct should be include poor governance of workers; workers not adhering to their own professional guidelines.

5.8 Discriminatory Abuse

A submission noted that all aspects of discrimination under law need to be under this definition.

5.9 Proposed Additional Categories of Abuse

A number of submissions advocated the inclusion of additional categories of abuse including:

- Coercive control, undue influence
- Modern day slavery/human trafficking
- Online abuse-A number of submissions highlighted this as an emerging issue which is evidenced by recent research and figures from An Gardaí Síochána
- Domestic Violence
- Racial/cultural abuse
- Self-neglect and self harm
- Hate Crime
- Identity Abuse: This is where an abuser can use an individual's sexual orientation, gender identity or HIV status to control and manipulate a person with the threat of 'outing' to family, friends, work colleagues etc. In such contexts, the person being abused would be concealing their sexuality. This is used by the abuser as a mechanism to control.

6.0 Recognising and Prevention

It was recommended that this section of the policy should be divided into two sections

1. Safeguarding and Preventing Abuse
2. Response to Concerns of Abuse

By far the most dominant theme requiring clarification and expansion in this section relates to capacity and consent. There needs to be a greater emphasis on consent, as many submissions felt that there is an overall lack of awareness and implementation of the HSE Consent Policy²⁰ that needs to be addressed.

The delay in the roll out of the Assisted Decision Making Capacity Act is causing confusion in the system, which requires clarification. Specifically, while awaiting this, there needs to be recognition by all workers, to learn to accept that where there is capacity that a person has the right to make decisions, even if these result in a negative impact. Additionally, where there are capacity issues every effort should be made to determine will and preference implementing the functional test.

Issues of concern that need clarification include:

Consent

- The management of risk when there is no consent. *“Respecting the right to self-determine is commendable however it may lead to adverse outcomes and we need to address what is the duty of care in these situations.”*
- Clarification required on the need for consent when a person has capacity, given that people have the right to refuse services including referral to services.
- A major area of concern is in relation to consent issues e.g. MSWs being advised to contact Gardaí or make a referral regardless of client's own wishes. Noted that this goes against the consent policy and the principles of the new Assisted Decision Making Act ²¹ as well as against IASW Code of Ethics²² in this area. The requirement to report under the 2012 Act is at times being misrepresented as the Act is more specific than the advice being given.

- This section states that “...*information is only communicated to others with the consent of the person involved*”. Some of the submissions noted that this is not the approach that has been taken when consulting with HSE’s Safeguarding and Protection Teams and a culture of mandatory reporting has developed. The legal position needs to be very clear and it needs to guide the process for reporting and sharing of information. This section finishes with a line that ‘on occasion’ the sharing of information will need to be carried out to protect a person, and by doing so without their consent, but this needs to be made clearer.
- Use of the term “meaningful consent” how is this determined?

Confidentiality

- Some of the submission noted the need for greater clarity in relation to **confidentiality** if, for example, a service-user who does not wish to escalate a concern. Others pointed out the importance of the duty to share information about an individual at risk, being viewed as, as important as the duty to protect. *“Proportionate information sharing can be challenging to achieve, given confidentiality issues, but can be important in preventing harm to the adult at risk and can facilitate preventative approaches.”*

Capacity

Some views advanced:

- *“As someone who has worked with and supported individuals who are deaf-blind (with additional severe and profound disabilities), it was difficult over the years to develop a person centre planning system that could empower individuals as well as reduce the risk of abuse and neglect.”*
- A general paternalistic view of people with intellectual disability is to be discouraged.
- There needs to be an explicit explanation or example of a functional assessment of capacity and which and how many professionals carries this out.
- Self-determination is important where someone is deemed to have capacity with regard to a decision made this SHOULD not be overridden without a

capacity assessment. “In normal circumstances” this requires clarification and MDT discussion / legal advice. Assisted decision making needs to be considered as well.

- Capacity is now assessed on a decision by decision basis and can take time to assess in busy hospital environments.
- Consider issues around cognitive impairment, which can stem from both learning disabilities and mental health issues

Complaints

A number of submissions noted that staff would find it beneficial to include some information on a decision making process that will assist people to decide which process needs to be followed when a concern arises, i.e. complaints, HR/Trust in Care, safeguarding, serious incidents.

The link with complaints is vital as many patients give feedback via this system.

The policy states that all “persons causing concern” should be informed that a complaint has been received and some submissions felt that this should be extended to their carers, when this person is a vulnerable adult themselves.

Anonymous and Historical Complaints

Submissions noted that there needs to be stated position on reporting concerns to TUSLA or An Garda Síochána, particularly if the historical concern was in relation to alleged child abuse. TUSLA have set up separate teams to deal with historic abuse allegations given the complexity of managing these cases. Some submissions argued that the HSE should consider this avenue for adult historical cases. Also highlighted was the need for clarity on working with persons who have allegations against them and their rights to natural justice and to appeal any negative assessments of risk.

Additional Areas

Communication

it may warrant to include a a section that details the benefit/necessity of alternative and assisted communication interventions that support persons, living with

communication difficulties (Prevention and early detection) as opposed to verbal self-report within the revised policy.

Training

There is a clear need for education and training for families and relatives expressed in the submissions. Families can be fearful of the consequences of the reporting process. There are no formal guidelines on if, and when, family members should be informed if their name is to be reported as a person of concern.

In addition, whilst the policy outlines information on recognising abuse, there needs to be more joined up / multidisciplinary training in this area. Some submissions noted that this should be mandatory for everyone working in adult services.

As part of their training, staff should have full knowledge and understanding of circumstance that may leave a vulnerable person open to abuse. This includes an understanding that people with an intellectual disability, cognitive impairment, dementia etc. may not display normal reactions to distress, fear or pain. This needs to be fully acknowledged and a care plan / person centred plan is put in place to ensure that staff understand the specifics of each individual. Some submissions noted the need for better guidance and training on appropriate touch and affection to be shown to service users. Other submissions highlighted need for clarity in training on what constitutes service user to service user abuse.

Barriers Disclosing Abuse

Submission recommended the following:

- High levels of dependency and refusal of families / carer/ partner to allow access to the vulnerable person.
- Specific concerns relating to domestic violence in non-heterosexual relationships
 - fear of disclosing sexual orientation/ gender identity
 - non- recognition of abuse because of domestic violence (DV) public image
 - fear of partner

- fear of not being believed because your partner is female and smaller than you
- not seeing yourself and your experience in service providers public image e.g. heterosexist add campaigns, promotional material, websites
- lack of awareness from services around same sex domestic violence
- being assumed heterosexual by nurses, GPS, staff in residential care homes
- fear of not having your claims taken seriously because your partner is a female

7.0 Operational Procedure

Streamline and improve documentation:

- The biggest issue for respondents in this section was with regard to the referral forms currently in use. The general concerns raised here related to the fact that the paperwork was lengthy, repetitive or required an unnecessary level of detail (one respondent queried if the process could be aligned with current data bases which hold much of the information regarding dates of birth etc).
- Because of the length of time consumed in filling out paperwork, some respondent felt that it took from other work that could be done including preventative work.
- An issue was raised about the ease of access for some service users with the suggestion that *“Further consideration should be given to the inaccessibility of the reporting process for a person with a disability who may wish to self-report. Currently a completed form must be typed and emailed. This may not be an accessible format for all individuals”*.
- There were a number of suggestions for changes to the structure of the various forms including a proposal that the Interim Safeguarding Plan could become the Full Safeguarding Plan in circumstances where there is no change to the plan in the three week period.
- A number of submissions referenced the other paper work which needs to be completed including notification to the National Incident Management

database and HIQA. Respondent queried if the Safeguarding referral could be streamlined with these forms.

- Contributors from the voluntary sector felt that the current policy discriminates because if concern is against a staff member they are not named while service users or others are named. They felt that data protection applies equally and staff should not be afforded special protections.

Realistic Timelines:

- The issue of tight timelines was raised by a number of respondents. Most felt that the expectation of a Preliminary Screening being submitted within three days was unrealistic, *“the imposition of such a tight time frame especially where there are no grounds for concern/no risk is unnecessary.”*

“Timeframes are ok as long as Safeguarding and Protection Teams take into account any rationale given on the preliminary screening for any delay in completing as the priority of ensuring safety of the individual may consume the initial 3 day period and this needs to be understood.” Another respondent commented; *“Totally unrealistic timescales for community”*.

Reporting thresholds and understanding of Zero tolerance requirement:

- The lack of a reporting threshold was raised by a number of respondents. One respondent pointed out that the threshold for reporting concerns’ regarding vulnerable adults is higher than that under the Children First legislation.
- The issue of thresholds was raised particularly in relation to peer-to-peer incidents. One submission commented; *“We question the no tolerance principle when it comes to peer to peer as there should be clinical judgement and a threshold present”*

“we suggest that DOs and other relevant staff such as the Social Work Team should be allowed to exercise their assessment skills as to whether a behavioural incident is a safeguarding incident.”

- The risk of inappropriately notifying service users to An Garda Síochána and almost “criminalising” a person who may themselves be vulnerable, was raised in this context too.

- The need to notify in all circumstances was raised by some submissions. A preliminary screening form 1 (PSF1) should not automatically be required i.e. if an incident is directly observed / witnessed and it is clear from the notification to the Designated Officer that the incident took place and that there are reasonable grounds for concern then there should be the option for the Designated Officer to go straight to Formal Safeguarding Plan 1 (FSP1).

Resource issues:

- It was pointed out that the work involved in meeting the requirements of the National Policy has time resource implications for organisations, particularly smaller organisations where the Designated Officer and the Person in Charge may be the same person.
- It was also pointed out that organisations may have no extra allocation for this work, have reduced staffing levels or be finding it difficult to recruit staff.
- There are resource implications in meeting the requirements of the Safeguarding Plans which can be difficult to meet, in circumstances where a PA service /alternative accommodation/ a specialist service is required
- The pressure on Safeguarding and Protection teams was mentioned a number of times and the shortage of Social Workers in this area of work.

Community and service referral pathways:

- Some submissions referred to the fact that safeguarding is everyone's responsibility and that this message needs to be emphasised in the revised policy.
- A number of submissions referred to their belief that the policy is overly focussed on the "service setting" or that the forms are "service based."
- The NFVB felt strongly that *"designated officers within a service setting should not be requested to undertake the preliminary screening for incidents which take place in a community setting without the required resources and governance agreements."*

8.0 Appropriate Structure/process to manage concerns

Operational model:

- A limited number of submissions made reference to preferred operational models, but those that did favoured a dedicated Vulnerable Adult Safeguarding Service. One respondent stated; *“It is also my opinion that safeguarding should be a standalone service/agency”*. The Safeguarding Principal Social Workers identified the challenges and the complex contextualised factors in developing a singular adult protection model.

Accompanying Operational Guidelines for Key Staff:

- A number of submissions sought the formulation of formal or practice guidelines for the assessment and management of safeguarding concerns for key staff. These should include;
 - Guidelines around liaison with An Garda Síochána,
 - Best practice on establishing capacity
 - Support and treatment post-abuse
 - Further expert input with assessment and investigation
 - Management of concerns in private nursing homes
 - Best practice on prevention.
 - Consent (and issues associated with the withholding of consent by the person referred).
 - Training and continuous professional development
 - Responsibility for the implementation of safeguarding plans for community residing service users

Greater Consistency of approach by Safeguarding and Protection Teams:

- Many submissions made reference to experiences of inconsistency in the application of the policy among the Safeguarding and Protection Teams. It was not always clear whether these related to intra or inter team variations. One submission noted; *“...has found that the current policy is being inconsistently implemented across HSE areas and across different types of*

services...”Another respondent commented that *“There is a lack of clarity about whose responsibility it is within the HSE to assess and investigate claims of abuse”*. A factor highlighted in this regard is the varying resource capacity across CHO areas.

Oversight considerations:

- The need for “Oversight” was mentioned on a number of occasions, both at the micro level (in the context of the overall management of cases) and at a macro level, in terms of service agreements of funded agencies, and national lead responsibility for adult safeguarding.

Need to Expand Scope and Coverage of Operating Procedures:

- Many submissions referenced the fact that the current policy is only operational across older person’s services and services for people with disability (HSE and HSE funded). One respondent commented; *“... in many cases individuals who are attending a mental health service do not have access to the service provided by the safeguarding team”*.
- Some submissions referenced the need for private nursing homes to come under the remit of the policy.
- Some submissions noted confusion as to the current scope of the policy.

Wording and Phrasing Issues of the Current Policy:

- A number of submissions pointed out language issues in the current policy or changes that should be made to the current language in any review of the policy.
- Issues with the current flowchart were mentioned on a number of occasions as being complex, vague and lacking clarity.

9.0 Organisational Role and Responsibility

9.1 For a Service Manager in Revised Policy

Submissions made the following recommendations for consideration:

- To have overall responsibility directing and supporting the Designated Officer (DO) and the Safeguarding and Protection Teams. It is integral that this role needs to be independent of the DO, which has not always been the case in the past which has caused issues.

“The service manager does have a key role in safeguarding and it is in our view their responsibility as the accountable manager to ensure that their staff

1. Comply with the national policy and procedures in the spirit of best practice

2. Take action when their staff are not complying

3. Attend and organise safeguarding managers’ meetings to look at the issues arising within their area and actions to be taken to address these.”

- Should decide who is best to lead on preliminary investigation and oversee process regularly reporting to CEO
- **Culture-**
 - Should be focused on patient wellbeing
 - Have a duty of care to educate and raise awareness among staff regarding the crucial role they each play in relation to reporting abuse and handling concerns. Including ensuring access to all relevant training.
 - Ensure that there are systems in place to gather feedback from service users on the quality of care and support they are receiving
 - Service managers should encourage an open culture of reporting and good processes to escalate concerns. Organisational culture can involve accepting the non-disclosure of errors or concerns for care quality. Tackling these challenges requires support for staff and ensuring they are not fearful of the consequences of their actions.
- Service managers should be included in all discussion relating to safeguarding incidents, as the latter will have expertise to bring to the team meeting and needs to be part of an integrated process.
- There is a requirement to have an IT system to provide managers with an overview of safeguarding concerns including alerts when outstanding information and safeguarding plans are due. This would be a system developed within Units, Services and for Managers within services /

community to have an overview of cases open to Safeguarding and to be aware of when Formal Safeguarding Plans are due / *and outstanding information should be flagged up within this computerised data base to enable more smooth running of safeguarding concerns.*

- Ensure a link between Quality and Patient Safety and Safeguarding in management of safeguarding concerns and poor practice.

9.2 For Front Line Staff in the Revised Policy

Zero tolerance

A number of the submissions argued for the continuance of the zero tolerance approach at the interface level as this is clear and easy to understand with potential threshold introduction at the Designated Officer level.

Culture

Key recommendations proposed

- Promoted the idea of a safeguarding champion within units / services identifying and highlighting areas of concern regarding the implementation of the safeguarding policy.
- Encompass the principals of safeguarding into all aspects of work and interaction with service users. Need to continue to promote the ethos that safeguarding is everybody's responsibility

"It is the responsibility of all frontline staff regardless of position etc to ensure that the policy becomes incorporated in the day to day management within each centre."

- Have a working knowledge of the safeguarding policy procedure and process.
- Promote the importance of raising concerns, and offering reassurance and positive feedback to those who do. This would encourage care providers to raise concerns at an early stage. Adequate support can lead to increased confidence levels and a sense of empowerment among staff, and ensure that the voice of the frontline is heard clearly at a senior level.

- Where the resource implications, appropriate safeguarding plans are provided for, thus improving the overall safeguarding experience for both staff and client
- Have front line staff more involved in strategy meeting and plans. Many contributors spoke of the need to have clear roles/ clear support/no ambiguity- including the provision of standard operating procedures.
- Ensure front line staff must be clear on their role and obligations, specific team members must be allocated safeguarding responsibilities and oversee care plans etc. opting out of this role cannot be an option

"It is vital that all front-line staff are aware of the importance of early detection and prevention, and respond to incidences of concern before they escalate. Front-line staff should be strongly supported and facilitated in the formal process around safeguarding. Too often staff may feel isolated and unduly stressed, and this can be compounded as a result of the perceived lack of support. Isolation and a lack of staff resources to manage concerns, once reported, have been indicated as a source of increased stress for front line workers. It is evident from a number of responses received that staff feel vulnerable to false allegations, and feel there can be misuse of power on staff by HSE management. This can result in staff feeling fearful and undermined and can create a culture whereby raising safety concerns are discouraged."

- Ensure they are fully informed of all formal safeguarding plans in place for residents / service user under their care (not exhaustive lists).
- Contribute fully to all team meetings particularly when discussing safeguarding / person centred care.

Other Issues Identified

Training

The provision of training was the most dominant theme reported by contributors including the provision of easy read documents, post training assessment (given the evidence of knowledge decay) and on-going training needs assessment to inform senior management.

Practice Handbook

That a handbook similar to TUSLA Child Protection Handbook be made available as soon as possible accompanying the launch of revised policy.

IT Support

There is a requirement for IT system, to improve efficiencies thus increasing time frontline staff time with clients.

Collaboration

Some submissions stated that there was a loss in community based work and collaboration with the move away from elder abuse workers, which has impacted on areas such as extreme self neglect and hospital discharge planning.

9.3 For Designated Officers (D.O.s) in the Revised Policy

The majority of respondents felt that it should be a stand-alone (separate to the service manager) and integrated within the governance structure of the acute residential and community services. The role requires additional on-going mandatory training that is linked to CPD. The D.O. should also be central in the roll out of training that promotes consistency in practice. They should be known to all members of the organisation which includes knowledge of their roles and responsibilities. In contrast others felt that it should be a generic role of all professional staff,

".....it should be assumed that all professionally qualified staff are DO's as part of their role and responsibility it should not be considered additional. Keeping services users free from abuse and identifying when abuse occurs and developing actions to stop and prevent further abuse as well as review and monitor all actions is part of the work of a professionally qualified staff member in any service setting. We believe this is where a mistake was made. Safeguarding should never have been introduced as a new concept and the D.O. role should have been the role of all professionally qualified staff."

Contributors also felt that there needs to be greater discussion/consultation on the role of the DO to include research, expert clinical practice, HR/Trade Unions,

Professional bodies in order to adequately establish this role. In order to fulfil this role there is a requirement for training in areas of validation, assessment, investigation, interviewing, chairing and interagency collaboration

The D.O. model has been successful with a service setting and contributors felt that this should be replicated in the community and extended into the private nursing home sector. Some contributors requested criteria on the extent of cover 24/7 and the numbers provided subject to organisational size.

Presently only those organisations expected to have a D.O. are services which are HSE and HSE funded. This leaves all other services without any duty to appoint a DO or report abuse according to the current HSE policy. Even if the service appoints a D.O. this person has no right of access to information, advice or support from the local Safeguarding and Protection Team. Across all services, D.O.s should have to engage in mandatory training and CPD.

Recommended Duties

- D.O.s need to ensure that they communicate availability of cover on an on-going basis
- Receive concerns/informs appropriate manager and ensures necessary actions are implemented
- Provide peer support
- Liaise with the Safeguarding and Protection Team on a 7 day week to seek advice/support
- D.O.s must be named and known to each member of the service where they are located. Their role and responsibilities must be clearly defined and supported.

9.4 For Safeguarding and Protection Teams in the Revised Policy

Improved Communication between Safeguarding Teams and Designated Officers

The most reported function of the teams related to improving the communication with the Designated Officers in the provision of training, advice and support, thereby

being more connected to the frontline service delivery. It was suggested that quarterly meetings should take place between team members and Designated Officers to discuss issues and concerns at a local level. Additionally, there should be representatives from Service Providers / HSE Funded Agencies on all local safeguarding committees, to address issues arising in relation to the implementation of the National Policy and ensure that there is consistency across the various CHO areas.

Greater Standardisation

Requirement for standard operating procedures or at least guidelines are required for teams, to avoid diversity of practice and response. This should include response timeframes, the extent of their duty to assess, when their role solely extends to giving advice and information, and case closures. This should be supplemented by a CRM system to record and analysis data at a regional and national level.

There is considerable variation in how teams operate across the country, in areas where the teams is more focus on oversight the Adult Social Work Service feel that *“the team are not available to engage directly in clinical work.....the safeguarding personnel have no opportunity to engage in practice, develop skills and support clinical work.”*

Some submissions felt that processing of decision making and the splitting of accountability is likely to negatively affect the professional relationship of those dealing with these difficult cases, which may in turn lead to negative outcome for clients.

Dispute Mechanisms:

A number of submissions recommended that there needs to be a national system for the resolution of disputes which arise between the members of a CHO Safeguarding and Protection Teams and a Service Provider. Specifically issues may relate to clinical practice decisions or have resource implications. Where differences of opinion arise there must be an ‘independent / external’ means of addressing same.

Recommended Duties

- Be part of the governance structure to include reviewing, risk assessments and risk management plan.
- Should support advice attend strategy meetings and assist in the development of Formal Safeguarding Plans in very complex cases- not having case responsibility, monitoring and reporting cases in each CHO area.
- The Safeguarding Team should have responsibility to provide an advice service and receive reports on concerns and complaints of alleged abuse of a vulnerable person. The team should play a strong role in advising and supporting care providers to respond to alleged abuse and assess and manage such cases

Composition

Teams should be strengthened in numbers, diversified by the inclusion on non-social worker safeguarding officers, and there should be consideration given to a system of prioritisation of reports received.

Other suggestions:

- The Safeguarding and Protection Teams should provide a clear evidential rationale when they suggest to Designated Officers that any other form of abuse other than that reported should be selected
- Need to fully undertake training requirements
- Clarity needed regarding how to manage engagement with alleged person causing concern in light of Barr Judgement²³ etc.
- In the longer term, an adult version of Tulsa needs to be established if the pathways and safeguarding skills are to be integrated into all services, and to also prepare for future safeguarding legislation
- Clarity required from the teams perspective on where the responsibility lies regarding delayed submissions of Safeguarding plans- Safeguarding and Protection Teams or HIQA
- Teams need greater clarity on how to safeguard in the presence of risk in the absence of consent
- Teams oversight role from staff of lower grade causing clinical governance issues

- Teams will need resourcing for expanded roles i.e. private nursing homes
- Teams need greater understanding of the disability field
- Beneficial if teams could access Multi-Disciplinary Teams (MDT) responses on safeguarding referrals
- Teams should directly assess particularly complex complaints and coordinate service responses needs to be reworded or removed as it is causing confusion
- Clarity required regarding the role of the team in retrospective allegations
- Teams need greater clarity required around risk assessment

10.0 Final Comment

On a positive note the Safeguarding Team structure has worked well and has been complemented by many contributors. In particular, reference was made to the “Principal Social Worker being in place has made a difference to approach to safeguarding” and indeed the multidisciplinary approach is working. However the following illustrates the potential pitfalls that could exist if the current model is continued,

“The safeguarding team have brought a professionalism to this area and are changing culture regarding the need to address adult abuse, I think as time goes on this team needs to be integrated, as short term assessment work has the risk of burn out and the consequence of shedding staff as job satisfaction maybe limited, rather the option of more mixed; long term case work with safeguarding work is in my opinion more satisfying and may help retain staff longer, this is my experience as a social work manager here and in UK.”

Additional Areas requiring attention:

1. Training and continuous professional development issues that were raised:

- There is a very urgent need to train staff in private and voluntary homes or at least allow access to HSE NMPD/ CNE training to ensure this policy is

embedded in practice, understood and implemented- with due consideration for payment for same

- Regular training of all staff, who are in daily contact with vulnerable persons, is vital and remains the surest way of spotting any concerns, reporting them and getting them investigated and stopped.
- The lack of a comprehensive accessible and available training programme regarding roles and responsibilities, procedures etc has had a significant negative impact both on the implementation of the policy and the functioning of the teams.
- Safeguarding Teams are not, in the current structure resourced adequately to deliver training. A Training Officer should be assigned to each team or each CHO operating out of the National Safeguarding Office.
- The safeguarding model needs to take into account the specific needs of various cohorts at risk, including people with dementia, and also an understanding of the challenges of dementia and the implications of this for the safeguarding process. Specific organisations should be enabled to adopt training that is consistent with the needs of service-users of that organisation.
- Training should incorporate the development and sharing of information in relation to best practice across service, in order to enhance safeguarding practices.
- Follow up training and workshops are essential for front line staff- additionally there is a need to address the challenges faced in reporting co-workers.
- Interagency joint training is recommended by a number of contributors.
- Cross divisional co-operation needs to be addressed in future training, such as resolution of areas - confusion between primary care and mental health when a client is shared as to who does what, in terms of safeguarding, even in cases where client has capacity.

2. Non Compliance

The policy currently places responsibility for implementation with the Head of Social Care in each CHO area. The current policy does not have a robust enough mechanism for non-compliance. It has been suggested that the revised policy should have a more detailed process as to what occurs when services do not meet their

requirements to improve accountability would be welcomed. The consideration on a practical level for a specified individual who acts as an arm of the CHO team with specific responsibility for oversight in this regard should be explored.

3. Resourcing Issues

The resourcing of the Safeguarding and Protection Teams is a dominant theme which impacts on the level of support that they can provide to services and the community in the oversight and management of safeguarding concerns. “Overwhelmed” is the word most often associated with the teams. This correlates with the burden experienced by some of the Designated Officers compounded with reference to the “administrative burden”. There is a fear that the preventative part of their role is being eroded.

“The significant increase in the number of notifications and the time and effort required to process reports has given rise to anecdotal evidence of workers at times feeling overwhelmed, experiencing compassion fatigue and burnout. This is important to consider within the threshold debate so that our collective focus is on responding well to truly serious concerns.”

A number of the submissions raised resource issues, “A protection plan is in place, but the concern remains because the cause is environmental and there are no resources to remove the person from the current circumstances. This raises the issue of the additional resources required and the need to make business cases or reallocate resources.”

4. Clarity of Definitions is Required

A number of the submissions highlighted the need for improved clarity on the application of definitions within the procedures

5. Appeals

A number of submissions raised the issue of an agreed appeals mechanism which should be in place for affected individuals who wish to challenge an outcome or the finding of a screening a safeguarding concern.

6. Liaison with An Garda Síochána

Some submissions argued for greater clarity on the grounds and rationale for reporting concerns to An Garda Síochána. The need for joint training and improved liaison with An Garda Síochána was highlighted. Some submissions noted concern about impact on service users if they are inappropriately notified to An Garda Síochána whilst other noted that some services may not always report potential criminal matters.

7. Ongoing Research and Evaluation

A number of submissions highlighted need for ongoing research and evaluation. There needs to be on-going research on the impact of the policy in increasing safety/less abuse of vulnerable adults. Also is the policy and procedures making effective changes into negative cultures and have we contributed to developing open and inclusive systems and organisations.

8. Confidential Recipient

Some submissions suggested greater clarity on the process as to the linkage and interface with the Confidential Recipient especially regarding the 'confidential' nature of the information which is provided by families / staff members and policies can contribute to good quality, continuously improving human services.

9. Support Resource Material

There needs to be further resourcing of support material including

- Clarity on the interactions with other policies and procedures to aid appropriate decision making
 - Trust in Care
 - NIMS
 - HIQA
- Easy Read Versions of the Policy and Training Packs- staff and service users
- Assessment tools
- The requirement for a safeguarding vulnerable adults practice handbook
- The requirement of a National Competence Framework

- The requirement for a National Accountability Framework is needed to ensure best practice across all areas and that there are appropriate response to emerging trends.

10. Compliance with Data Protection

Some of the submissions on data protection noted:

- "Policy on storage of data relating to safeguarding should be much clearer
- Organisations need much more support with the area of risk assessment and risk management as well as incident management. It would be helpful if each organisation had a community team (like the Safeguarding Team) who they could call upon for support with training staff in such areas. This would be particularly useful where there are national policy changes.

11.0 References

- ¹ Hse Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures(2014)
<https://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf>
- ² Assisted Decision Making (Capacity) Act (2015)
(<http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>)
- ³ Criminal Law (Sexual Offences) Act (2017)
<http://www.irishstatutebook.ie/eli/2017/act/2/enacted/en/html>
- ⁴ NO Secrets Review Consultation (UK) (2009)
http://webarchive.nationalarchives.gov.uk/20121011124141/http://www.dh.gov.uk/pr od_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102981.pdf
- ⁵ The Law Commission (UK) (2011)
http://www.lawcom.gov.uk/app/uploads/2015/03/lc326_adult_social_care.pdf
- ⁶ (Adult Services Report 41 SCIE Prevention in Safeguarding p5)
<https://www.scie.org.uk/publications/reports/report41/>
- ⁷ Stewart, Ailsa E. (2016) The implementation of Adult Support and Protection (Scotland) Act (2007). PhD thesis
<http://theses.gla.ac.uk/7083/1/2016StewartPhd.pdf>
- ⁸ Sherwood-Johnson F (2012) Problems with the Term and Concept of 'Abuse': Critical Reflections on the Scottish Adult Support and Protection Study, *British Journal of Social Work*, 42 (5), pp. 833-850.
<https://academic.oup.com/bjsw/article/42/5/833/1711319>
- ⁹ The 2017 De-Stress study of carer well-being undertaken by the ASI, Trinity College <https://alzheimer.ie/getattachment/ea65fa82-f5da-4b34-bc4c-86fa3e04b15a/De-Stress-Report-2017.pdf.aspx?ext=.pdf>
- ¹⁰ The NI Safeguarding Policy
<https://www.health-ni.gov.uk/adult-safeguarding-policy.pdf>
- ¹¹ Adult at risk - Section 3(1)
- ¹² Rapid Realist Review conducted by Donnelly et al (2017)
- ¹³ Alzheimer's Society of Ireland has developed a Charter of Rights in 2016
<https://www.alzheimer.ie/getattachment/About-Us/Policy/Human-Rights/A-Charter-of-Rights-for-People-with-Dementia/Charter-of-Rights-for-People-with-Dementia.pdf.aspx>
- ¹⁴ Office of the Ombudsman, Complaints and Complaint Handling (2015)
<http://m.ombudsman.gov.ie/en/publications/guidelines-for-public-bodies/model-complaints/model-complaints.pdf>
- ¹⁵ Assisted Decision Making (Capacity) Act
<http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>
- ¹⁶ Programme for Partnership Government (2016)
https://merrionstreet.ie/MerrionStreet/en/ImageLibrary/Programme_for_Partnership_Government.pdf
- ¹⁷ HSE Elder Abuse Policy (2012)
<https://www.hse.ie/eng/services/publications/olderpeople/elderabusepolicy2012.pdf>
- ¹⁸ Northern Ireland Adult Safeguarding Policy (2015)
<https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>
- ¹⁹ New Directions: REVIEW OF HSE DAY SERVICES AND IMPLEMENTATION PLAN 2012 – 2016
<https://www.hse.ie/eng/services/publications/disability/newdirections2012.pdf>

²⁰ HSE Consent Policy (2013)

<https://www.hse.ie/eng/services/list/3/nas/news/national-consent-policy.pdf>

²¹ Assisted Decision Making (Capacity) Act 2015

(<http://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html>)

²² IASW Code of Ethics (2007)

<https://www.iasw.ie/attachments/8b37e75a-26f6-4d94-9313-f61a86785414.PDF>

²³ Barr Judgement. M.Q. v. Robert Gleeson, The City of Dublin Vocational Education Committee, Francis Chance and The Eastern. Health Board [1998] 4 IR 85.

12.0 Appendices

Appendix 1 – Written Submissions Template



National Safeguarding Office

HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures
FORMAL SUBMISSIONS

INTRODUCTION

"The HSE National Safeguarding Office, on behalf of the HSE Review Development Group, is now seeking formal submissions on the review of Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures 2014."

Submission Template

The HSE published the "Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures" in 2014. A copy of the safeguarding policy is available to [view here](#)

This policy is now being reviewed and the HSE Safeguarding Review Development Group (RDG) would like to hear the views of the public, service users, staff, family representatives, advocates and interested organisations on suggestions for inclusion in a revised policy.

The Review Development Group recently completed Phase 1 of the review process. Phase 1 considered the current operation of the existing policy including materials submitted such as the staff online survey. The review process has now moved to Phase 2 which incorporates this formal submission request.

To effectively collect feedback, the HSE Review Development Group has prepared a standard template for individuals and organisations to provide their submissions. This submission template is provided as a guideline only.

Should you have additional information or wish to make a free form submission please feel free to do so in the relevant section. If there is any section that is not relevant to you or your organisations please insert not applicable as appropriate.

Written copies of any submission can be also be sent by email to : safeguardingreview@hse.ie or by post to: National Safeguarding Office, South East Wing, St Joseph's Hospital, Mulgrave Street, Limerick

Confidentiality & Data Protection

This submission form is for policy review purposes only. If you would like to make a specific comment, compliment or complaint to the health services, please contact your health service provider in the first instance, go to www.healthcomplaints.ie or email the HSE (if applicable) at yoursay@hse.ie, phone 1890-424-555.

The information shared by you in this submission form will be used solely for the purposes of policy development and handled in accordance with data protection legislation and standards on confidentiality. The results of the consultation and revised policy will be published along with a list of organisations that responded. Comments submitted by individuals may be used in the review process and will be anonymised. All personal data is securely stored and subject to data protection

laws and policies. For more information, see www.hse.ie/eng/services/yourhealthservice/info/DP/. Please note that any submissions received by the HSE are subject to the Freedom of Information (FOI) Act 2014 and may be released in response to an FOI request.

Closing date:

Please note that the closing date for receipt of submissions is 29th September 2017.

If you have questions or require assistance about sending a submission, please contact the National Safeguarding Office by email on safeguarding.review@hse.ie or by phone on 061-461165.

1. Indicate if you are making a personal submission or a formal submission on behalf of a service or Organisation

☐ Service/Organisation

☐ Personal

2. Please indicate if you or your organisation would like to be considered for further contact or as part of a focus group engagement?

☐ Yes

☐ No

3. At what email address would you like to be contacted for focus groups participation?

4. Please provide Contact Details:

Name

Phone Number

Organisation

Position



National Safeguarding Office

HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures
FORMAL SUBMISSIONS

Section A- Commentary on the current policy and opening Statement.

5. Do you wish to make a Statement or comment on the current safeguarding policy?

6. Do you wish to make a free forum opening Statement?



National Safeguarding Office

HSE Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures
FORMAL SUBMISSIONS

Section B - Definitions & Principles

7. The current safeguarding policy 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."*

What do you think is the appropriate wording or language to describe adults at risk of abuse who are to be covered by this policy?

8. Who are the adults at risk of abuse that you think should be covered in a revised HSE safeguarding policy?

9. The current safeguarding policy has a set of key core principles and Human Rights Statements:

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:

D [Human Rights](#)
D [Person Centeredness](#)
D [Advocacy](#)
D [Confidentiality](#)
D [Empowerment](#)
D [Collaboration](#)

What would you like in any amendments or changes to these principles and human rights statements?

10. The current policy has a section on the [core definitions of abuse concerns](#) (see pages 8/9 of the policy).

The current policy has an overall definition of abuse as follows:

"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."

What would you like in any change or amendment to this definition?

11. The current policy has an overall definition of physical abuse:

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

What would you like in any change or amendment to this definition?

12. The current policy has an overall definition of sexual abuse:

"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"

What would you like in any change or amendment to this definition?

13. The current policy has an overall definition of psychological abuse:

"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"

What would you like in any change or amendment to this definition?

14. The current policy has an overall definition of financial abuse:

"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"

What would you like in any change or amendment to this definition?

15. The current policy has an overall definition of neglect:

"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"

What would you like in any change or amendment to this definition?

16. The current policy has an overall definition of institutional abuse:

"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"

What would you like in any change or amendment to this definition?

17. Please provide any other views that you would like to be considered in relation to the definition's of abuse (any suggested additional categories of abuse or potential abuse by one adult service user to another etc)

18. The current policy has a section on the [recognition and prevention of abuse](#) (see pages 19/22 of policy).

This section includes relevant issues such as early detection, capacity, consent, confidentiality and complaints.

What amendments or changes would you recommend to this section?



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Section C- Safeguarding Policy & Procedures

19. The current safeguarding policy has a detailed [operational procedure](#) (see page 23-41 of the policy).

How would you propose changing or improving the procedures to respond to concerns or allegations of abuse?

20. Would you like to make a submission regarding the appropriate organisational structures and process to manage concerns or allegations of abuse?

21. Would you like to make a submission regarding the organisational role and responsibility for a service manager in the revised policy?

22. Would you like to make a submission regarding the organisational role and responsibility for front-line staff in the revised policy?

23. Would you like to make a submission regarding the organisational role and responsibility for a designated officer in the revised policy?

24. Would you like to make a submission regarding the organisational role and responsibility for safeguarding team members in the revised policy?



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Section D Additional Information

25. Please provide any other comments either negative or positive on your experience with adult safeguarding that could assist in the revision of this policy?

26. Please provide any other views or relevant information that you would like to be considered as part of your submission.



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FORMAL SUBMISSIONS

Appendix 2 – References in Written Submissions

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|---|---|
| Clinics in Geriatric Medicine, Joshi and Flaherty, 2005 | Clinics in Geriatric Medicine Volume 21, Issue 2, May 2005, Pages 333-354 http://www.sciencedirect.com/science/article/pii/S0749069004001260?via%3Dihub |
| Child Protection and Welfare Practice Handbook - Tusla | http://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf |
| SICE Protecting adults at risk: Good practice resource | https://www.scie.org.uk/publications/adultsafeguardinglondon/files/protecting-adults-at-risk-in-london.pdf |
| Children First Act 2017 | http://www.tusla.ie/uploads/content/Children_First_National_Guidance_2017.pdf |
| Stewart, Ailsa E. (2016) The implementation of Adult Support and Protection (Scotland) Act (2007) | http://theses.gla.ac.uk/7083/1/2016StewartPhd.pdf |
| Exploring the meaning of protection from abuse: Problem construction in Scottish adult support and protection practice and policy | https://dspace.stir.ac.uk/bitstream/1893/17004/1/Contextualising%20document%20Aug%202013.pdf |
| NO Secrets Review Consultation (UK) | https://cml.sad.ukrd.com/document/245156.pdf |
| SICE Protecting adults at risk: Good practice resource | https://www.scie.org.uk/publications/adultsafeguardinglondon/files/protecting-adults-at-risk-in-london.pdf |
| NI Safeguarding Policy | http://www.hscboard.hscni.net/download/PUBLICATIONS/SAFEGUARDING%20VULNERABLE%20ADULTS/guidance_and_protocols/Adult-Safeguarding-Operational-Procedures.pdf |
| Assisted Decision Making (Capacity) Act | http://www.citizensinformationboard.ie/downloads/relate/relate_2016_04.pdf |
| The Adult Support and Protection (Scotland) Act 2007 | http://www.legislation.gov.uk/asp/2007/10/pdfs/asp_20070010_en.pdf |
| MENTAL HEALTH ACT 2008 | http://www.mhcirl.ie/File/MHA2008.pdf |
| Adult Support and Protection Code of Practice | http://www.gov.scot/Publications/2014/05/6492/3 |
| Making decisions on behalf of mentally incapacitated adults A consultation paper issued by the Lord Chancellor's Department | http://webarchive.nationalarchives.gov.uk/+http://www.dca.gov.uk/menincap/meninfr.htm |

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| Assisted Decision Making (Capacity) Act | http://www.citizensinformationboard.ie/downloads/relate/relate_2016_04.pdf |
| RESIDENTIAL CARE AND OLDER PEOPLE | http://www.cpa.org.uk/policy/briefings/residential_care_and_older_people.pdf |
| HEALTH ACT 2007 | http://www.irishstatutebook.ie/eli/2007/act/23/enacted/en/pdf |
| (CARE AND WELFARE OF RESIDENTS IN DESIGNATED CENTRES FOR OLDER PEOPLE) REGULATIONS 2013 | https://www.hiqa.ie/system/files/Regulations-2013.pdf |
| SICE Protecting adults at risk: Good practice resource | https://www.scie.org.uk/publications/adultsafeguardinglondon/files/protecting-adults-at-risk-in-london.pdf |
| Child Protection and Welfare Practice Handbook - Tusla | http://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf |
| SICE Protecting adults at risk: Good practice resource | https://www.scie.org.uk/publications/adultsafeguardinglondon/files/protecting-adults-at-risk-in-london.pdf |
| NO Secrets Review Consultation (UK) | https://cml.sad.ukrd.com/document/245156.pdf |
| Sage | http://www.thirdageireland.ie/sage |
| <u>Keep control safeguarding your finances in later life</u> | http://www.keepcontrol.ie/financialabuse_whatitisit |
| <u>SICE Protecting adults at risk: Good practice resource</u> | https://www.scie.org.uk/publications/adultsafeguardinglondon/files/protecting-adults-at-risk-in-london.pdf |
| <u>NO Secrets Review Consultation (UK)</u> | https://cml.sad.ukrd.com/document/245156.pdf |
| <u>Harrow</u> | http://www.harrow.gov.uk/info/200184/adults_at_risk/749/organisational_or_institutional_abuse |
| <u>sense.org.uk</u> | https://www.sense.org.uk/ |
| <u>IASW Code of Ethics</u> | https://www.iasw.ie/attachments/8b37e75a-26f6-4d94-9313-f61a86785414.PDF |

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| <u>Assisted Decision Making (Capacity) Act</u> | http://www.citizensinformationboard.ie/downloads/relate/relate_2016_04.pdf |
| <u>Inter Divisional Document</u> | Share drive: written sub lit folder- Safeguarding Vulnerable Adults for Abuse – Inter Divisional Approach. |
| <u>National Consent Policy</u> | http://www.hse.ie/eng/services/list/3/nas/news/National_Consent_Policy.pdf |
| <u>NIMS</u> | https://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf |
| <u>Leas Cross Review</u> | http://www.hse.ie/eng/services/publications/olderpeople/Leas_Cross_Report_.pdf |
| <u>A Charter of Rights for People with Dementia</u> | https://www.alzheimer.ie/getattachment/About-Us/Policy/Human-Rights/A-Charter-of-Rights-for-People-with-Dementia/Charter-of-Rights-for-People-with-Dementia.pdf.aspx |
| <u>De-Stress: A study to assess the health & wellbeing of spousal carers of people with dementia in Ireland.</u> | https://alzheimer.ie/getattachment/ea65fa82-f5da-4b34-bc4c-86fa3e04b15a/De-Stress-Report-2017.pdf.aspx?ext=.pdf |
| <u>A view from the Department of Health</u> | Z:\Review 2016\Written submissions\Literature Highlighted in submissions |
| <u>Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.</u> | www.midstaffspublicinquiry.com/report |
| <u>Outcomes following adult safeguarding alerts: A critical analysis of key factors.</u> | Z:\Review 2016\Written submissions\Literature Highlighted in submissions |
| <u>Elder Abuse and Neglect in Long-Term Care</u> | Clinics in Geriatric Medicine Volume 21, Issue 2, May 2005, Pages 333-354 http://www.sciencedirect.com/science/article/pii/S0749069004001260?via%3Dihub |
| <u>Problems with the Term and Concept of 'Abuse': Critical Reflections on the Scottish Adult Support and Protection Study</u> | Z:\Review 2016\Written submissions\Literature Highlighted in submissions |
| <u>Scottish Adult Support and Protection Study</u> | https://academic.oup.com/bjsw/article/42/5/833/1711319 |
| <u>The implementation of Adult Support and Protection</u> | http://theses.gla.ac.uk/7083/1/2016StewartPhd.pdf |

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| <u>Outcomes following adult safeguarding alerts: A critical analysis of key factors</u> | Z:\Review 2016\Written submissions\Literature Highlighted in submissions |
| <u>ASI's Charter of Human Rights</u> | https://www.alzheimer.ie/Alzheimer/media/SiteMedia/ImageSlider/Fixed/ASI-HROP-A4-Online-Report.pdf |

