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

"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."

The HSE published the "Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures" in 2014. 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.

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

This Submission represents the views and responses of ASI staff, including Operations Managers and front-line staff. While many staff agree that the Safeguarding policy is clear and concise in the context of protecting vulnerable people at risk of abuse, staff are also in agreement that there are aspects of the policy that require serious consideration and revision. The organisational model of safeguarding in Ireland, reflecting a single agency model with multiple responders, needs to work in partnership with all relevant service providers and staff, forming an integrated and coherent collaboration with front-line staff, service managers, Safeguarding Teams, HSE senior managers and primary care teams.

The individual, their decisions and stated outcomes need to be placed at the centre of the process. People with dementia may have co-morbidity and multiple medical conditions. Their dependency on others for care may make them particularly vulnerable to abuse and neglect (Joshi and Flaherty, 2005). In some cases, where concerns or allegations of abuse are not adequately addressed, this can result in the person at risk requiring long-term care and/or entering hospital. A person-centred approach to safeguarding, in some cases, can facilitate and support the person at risk to remain at home in the community, or indeed in a day care respite centre.

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?

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), 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. Sherwood-Johnson (2012) identifies 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-Stress 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.

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

The safeguarding policy should not be confined to a specific age, and instead should include all adults over the age of 18 years. It should cover all adults with a cognitive, physical and/or mental health issue who may be restricted in capacity for a defined period of time or on a sustained basis.

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:

- *Human Rights*
- *Person Centeredness*
- *Advocacy*
- *Confidentiality*
- *Empowerment*
- *Collaboration*

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

ASI has developed a Charter of Rights for people with dementia, which incorporates a PANEL approach, emphasising principles of participation, accountability, non-discrimination, empowerment, and legality (see link in bibliography). Launched in 2016 by former president Mary Robinson, the Charter acknowledges that people with dementia have the right to access appropriate levels of care providing protection and support. People with dementia have the right to health and social care services provided by care providers and staff who have had appropriate training on dementia and human rights to ensure the highest quality of services. Moreover, it states that those responsible for the care and treatment of people with dementia should be held accountable for the respect and protection of their human rights and adequate steps should be adopted to ensure this is the case.

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 a human rights based approach to safeguarding it need to move from the current model of 'best interests' to a model that treats the individual as central to the process.

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?

This overall definition of abuse should acknowledge that abuse can occur between service-users, which in the case of dementia can be unintentional or non-deliberate, as the service-user with dementia may lack self-awareness and reflexivity.

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?

ASI agrees with the broad definition above and, to some extent, to subsequent definitions relating to sexual, psychological, financial, institutional abuse and neglect. Notwithstanding, it would be helpful if said definitions could be de-constructed to include an understanding of the meaning of each type of abuse and neglect. Broad definitions can make it difficult to identify specific abuse, and including examples can help clarify this. For example, financial abuse includes a family member who repeatedly pressures the person at risk for money or borrows money, but never repays it or adult children who take some the person's pension without consent.

Other examples of abuse, which should be included with each definition of abuse, are:

- Discouraging visits or the involvement of friends or relatives,
- Not providing assistance with eating, or adequate food and drink,
- Failure to provide care with dentures, spectacles or hearing aids,
- Failure to provide access to meaningful activities,
- Not offering choice or promoting independence,
- Insufficient staff or high turnover resulting in poor quality care,
- Interference with personal correspondence or personal communication,
- Misuse of medication,
- Failure to manage resident with responsive behaviour,
- Failure to respond to complaints.

Further defining various definitions 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 policy document, they should be highlighted earlier in the document.

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?
In addition to the above, there is a need to consider historic abuse, inappropriate sexual language or intimidation via sexual language in any amendments to the definition.

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?

See above suggestion regarding the need for in-depth examples. It is also important to bear in mind that some psychological abuse between service-users is unintentional as some disabilities mean that service-users may not be able to differentiate between right and wrong.

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?
See above also. It needs to be recognised that financial abuse by family members can be subtle and family members themselves may be unaware that taking twenty euros from their mother's purse is theft, as pointed out above.

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?
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.

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?
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. Further, more clarity is required in relation to institutional abuse so that historical practices can be challenged.

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)

As mentioned above, abuse by one adult service-user to another should be considered for inclusion in the definition. Such abuse could simply comprise one service-user invading the privacy of another service-user, and this can lead to upset and distress.

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 his section?

There needs to be greater awareness of early detection and prevention. Early detection is essential to preventing abuse and this policy section should further highlight the significance of early detection and intervention as oppose to allowing an abusive scenario develop. While the policy acknowledges common organisational risk factors, such as low staffing numbers and weak management, it should also outline and clarify further indicators of abuse, including:

- People being hungry or dehydrated,
- Poor standards of care,
- Lack of personal clothing and possessions and communal use of personal items,
- Absence of visitors,
- Few social, recreational and educational activities,
- Public discussion of personal matters,
- Absence of person-centred care plans,
- Not getting consent or explaining procedures prior to caregiving.

This section in the policy report should also emphasise the supports that are available for the care provider who reports concerns of incidents of abuse, as it can be particularly stressful for the latter.

There is a need for further clarity in relation to confidentiality if, for example, a service-user does not wish to escalate a concern, and whether this concern should be shared with the Designated Officer. The duty to share information about an individual at risk should be viewed 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.

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?

There can be inconsistency in the operation and practice of Safeguarding Teams. Procedures are not enacted in the same manner in various CHOs by Safeguarding and Protection Teams and responses to concerns are implemented in different ways. Different responses to concerns across CHOs mean there are discrepancies in the overall safeguarding process. A standardised response is need and the care provider needs to be reassured that the concern will be addressed in a person-centred way, and within a reasonable time frame. Consistency in approaches to safeguarding can be achieved through training and day-to-day interagency working, and overtime, this can lead to a common language and understanding of the different concepts associated with safeguarding.

Procedures should include stronger communication protocols. There appears to be an issue regarding communication between referrers/services and some of the Safeguarding Teams, as

detailed further below. Non-engagement in the process by members of the Primary Care Team, including GPs and PHNs, as also mentioned below, can also impact negatively. Without the support and engagement of GPs and PHNs it is acutely difficult to progress a safeguarding concern, and this can be a source of immense frustration for care providers. GPs may be reluctant to engage in a possible abuse situation if they personally know the family. Nonetheless, primary care practitioners need to be more involved and engaged in the safeguarding process and collaborate more closely with care providers when a concern about possible abuse is raised. Their training in relation to safeguarding protocols should be updated and reviewed, and their role in relation to handling an allegation of abuse needs to be clearly defined in relation to the care provider who raises the concern. If such concerns are detected and addressed at an early stage, it can prevent an abuse scenario from escalating, protect the person at risk, and engaging in a full and challenging process of safeguarding may not then be necessary. The policy needs to emphasise that primary care practitioners can play a critical role in early detection of abuse and in helping resolve such incidents.

A lack of capacity and resources can hinder the implementation of a safeguarding plan. There is a sense of frustration pertaining to safeguarding planning, as all too often recommendations are not able to be implemented due to lack of funding, which means that while a risk is recognised there is little that can be done to address it in any effective manner as resources are not available. . This policy needs to be backed by more concrete resources. Otherwise safeguarding concerns will not be adequately addressed and resolved in a timely way.

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

The HSE and ASI operate under strong organisational structures and process to address concerns of abuse. Effective safeguarding cannot be achieved without organisations working collaboratively to ensure the safety of the adult at risk is prioritised. There needs to be good communication across the sector. However, within the single agency model approach with numerous responders, care providers reporting abusive situations can feel isolated and unsupported. Gaining support from the Primary Care Team, including GPs and Public Health Nurses can be challenging, and this can be a result of time pressure and resource constraints. Nonetheless, the safeguarding process should be better supported and facilitated and should happen in a timelier manner. Effective and timely sharing of information between organisations is crucial to deliver high quality adult safeguarding services that are person-centred, focused on the needs of the adult.

The service-users' experiences, choices and aspirations need to be central to safeguarding, rather than a focus on tasks, processes and procedures, and an organisational culture concerned with the latter can lead to neglectful practices (Francis, 2013). There needs to be a culture of challenging poor practice before it escalates, fostering an open culture, challenging dominant individuals, organisational learning and reflection from safeguarding incidents.

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

The service/line manager, of ASI 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. However, often service managers do not feel included or supported in the safeguarding process. 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.

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.

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

It is vital that front-line staff, including nurses, carers, catering staff, cleaners, drivers etc., are aware of the important of early detection and prevention, and respond to incidences of concern before they escalate. Front-line staff should to 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.

There should be an organisational shift to promoting 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.

There can be concern about the workload implications of safeguarding, as it may pose challenges by diverting front-line staff away from their other work. If not properly resourced therefore, the safeguarding model can increase workloads and also stress levels.

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

ASI has appointed its own national Designated Officer on safeguarding vulnerable persons at risk of abuse. The Operations Managers in the 4 operation areas are also Designated Officers who take responsibility for this role. With specific HSE training in safeguarding, ASI's Designated Officer is responsible for receiving concerns or allegations of abuse from the line managers ensuring the appropriate manager is informed and necessary actions are identified and implemented.

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

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. Key issues emerging from staff views on this Submission include responsiveness/processing delays and inconsistencies between teams regarding their roles and responsibilities. ASI staff often feel that the response of the Safeguarding Team can be ineffective, inadequate and patchy. Despite the urgency of concerns about possible abuse, the response can be slow and ineffectual, even though time may be critical. In some instances, the response is so slow that the Gardaí have to be called to address the issue.

A number of staff have reported that they have found it challenging to ascertain the role and function of the teams. Within the Safeguarding Team, there should be clarity around roles and clarity in terms of the authority of the team.

ASI staff often perceive there is a stigma associated with raising concerns, and report feeling anxious and fearful about the response they will receive from the Safeguarding Team and the HSE. In some cases the response is muted and unhelpful, "Sure they're a lovely family and wouldn't mean to cause harm". There can be a sense of blame attributed to the care provider who is reporting the concern, and some staff feel that it is made their undue responsibility to address the issue and find alternative services for the person at risk. This response clearly indicates that there is a critical need to address the culture and environment within which Safeguarding Teams operate.

There is a need to improve staff collaborations between Safeguarding Teams and those working with people at risk. The Safeguarding Team should listen carefully to the views of all parties involved, act promptly, and record and document all relevant details. It is crucial that the Safeguarding Team provides regular updated training to staff and maintains information and records. Adequate training in safeguarding protocols is essential in steering staff into appropriate actions if abuse is suspected.

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

The concerns highlighted above raise specific and crucial issues that need to be directly addressed, and issues around organisational culture will require particular effort to address and change. 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.

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

Research indicates that the extent of multi-agency cooperation may impact on outcomes and is affected by different ways of organising safeguarding (Fyson & Kitson, 2012). This needs to be given serious consideration in this case, and communication and understanding between various parties involved in safeguarding needs to be better facilitated and supported. There should be a uniform process for how CHOs should carry out their safeguarding duties. Otherwise ambiguity develops as to how safeguarding work should be organised and undertaken.

Safeguarding that is person-centred is more likely to encourage involvement on the part of the person at risk, make them willing to collaborate and produce their own solutions (Crawley, 2015). ASI's Charter of Human Rights, developed with the support of its Working Group, can provide guidance on how a person-centred approach, emphasising principles of empowerment and participation, can guide the development of a safeguarding model and would offer an appropriate and effective lens through which to understand and facilitate safeguarding people at risk.

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