Head Medical Social Work (HMSW) Forum Feedback on Draft HSE Adult Safeguarding Policy

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The HMSW Forum is a national group made of up Medical Social Work (MSW) Managers/those in management roles in hospitals and hospices across Ireland. We are affiliated to the IASW but also an independent forum. Many hospitals are not directly under the current policy but are referring into safeguarding and Protection Teams (SPT's) while others (particularly those in the Disability Sector) who are funded through social care are expected to fully operate the policy within their agencies.

Some of the key areas which wish to comment on are as follows:

1. Social Workers are not specifically referred to in the draft policy at any point. We believe that the lead profession should be Social Work due to the specialist competencies such as managing risk, balancing rights, relationship based practice and client self-determination.

2. This draft policy is based on the principle that safeguarding is everybody's responsibility. While we agree that all Social Workers have particular skills and can provide intervention, it still requires a properly resourced specialist service for investigation and intervention on more complex cases. The loss of the collaborative working which was so effective when Senior Case Workers were still in existence is still keenly felt. It is not realistic that the role of safeguarding teams in working directly with vulnerable adults in risk situations can devolve to frontline hospital services who have a critical service to deliver.

   In summary, we feel that a specialist National Safeguarding Social Work Service needs to be established similar to Child Protection in Tusla (Centralised Specialist Model). This is crucial if the pathways and safeguarding skills are to be integrated into all services and to facilitate preparation for future safeguarding legislation. Pathways in relation to taking a vulnerable adult into a place of safety, support services to enhance safeguarding in home situations and investigation skills needed for complex cases or where there is serious institutional abuse would come under the remit of a central established agency. Social Workers would welcome co-working or screening out of inappropriate referrals as they currently do for child protection and recognise the need for effective inter-agency cooperation on these issues. Where it is appropriate for Medical Social Workers to be involved, they cannot be responsible for investigating safeguarding concerns or allegations without additional resources while already holding large caseloads. This would place other critical services at risk and lead to issues such as increased length of hospital stay. MSW's have found that SPT's have

unrealistic expectations of the hospital Social Worker's remit in terms of assessment and follow up of cases – most Social Work Teams are already at maximum or over capacity and deal with numerous crises throughout the day. SPT's have generally been unwilling to come into hospitals to meet with patients/families. There is also no clarity within the draft policy as to what the expectations would be of Medical Social Workers once the person has left the hospital.

3. The HMSW Forum welcomes the shift in this draft towards alignment with the Assisted Decision Making (ADM) Act. A major area of concern as been in relation to consent issues e.g. MSWs being advised to contact Gardai or make a referral regardless of client's own wishes. This goes against the consent policy and the principles of the new Assisted Decision Making Act, the UN Convention on the Rights of People with Disabilities as well as against the IASW and CORU Code of Ethics. The requirement to report under the 2012 Act is at times being misrepresented as the Act is more specific than the advice being given. The commitment to the ADM, decision specific capacity assessment and the right of clients who have the necessary decision making ability must be specifically stated within the policy.

4. The issue of thresholds for reporting has not been addressed within the draft and has been deferred to the Practice Handbook which has been unavailable for consultation. It is an area of major concern and no submission can be complete without sight of this key document.

   We consider that current thresholds for reporting are too low – behavioural incidents such as peer to peer events which are appropriately managed by the hospital should be logged and open to audit but not necessarily lead to referral to SPT and/or preliminary screenings. We agree that cases which are not referred should be logged and open to review or external audit to try to ensure zero tolerance and cultural change on the ground. We would welcome a change in the policy whereby the person raising the concern could consult with the DO to see if this constitutes abuse rather than having to do a preliminary screening simply because it was reported to the DO. There is currently no mechanism to screen out inappropriate referrals. We feel that Social Work training in assessment and risk should be valued in this regard. We suggest that some sort of matrix/guidance with regard to harm and risk could be used to support clinical judgment and assessment

5. There is a lack of clarity as to what level of training will be expected in busy hospital environments and how this will be managed. The resource implications of the policy for hospital staff and for Social Work Teams in particular need to be seriously considered.

6. Apart from staff resources, the necessary support services for patients such as home care packages, respite care, residential placements etc which may

be essential for safeguarding of a vulnerable adult need to be in place. Many MSW's find it difficult to secure these necessary services on a day to day basis. There is no commitment to resourcing the necessary services to assist safeguarding intervention.

7. We are extremely concerned that private Nursing Homes are excluded from this policy. Many of our most vulnerable patients both over and under 65 years reside in Nursing Homes and/or being discharged to nursing homes. Many are fully or partially funded by the State through the Fair Deal Scheme and we feel that this is sufficient grounds to include this group.

8. Some of the MSW's in the Hospice sector have had referrals turned down on the basis that these patients are not vulnerable adults whereas in fact, these are some of our most vulnerable clients and must not be excluded. The existence of pre existing issues such as domestic violence has resulted in referrals to SPT's not being accepted. SPT teams have advised that because the concern pre-dated the illness, it does not fall under the policy. However, the person's ability to protect themselves is seriously compromised by the extent of their illness and this is not considered by the SPT's

9. The correlation between the safeguarding policy and Trust in Care needs to be clarified and reviewed – we feel that it is important to include time lines in terms of investigations and resolution. There needs to be clarity in relation to issues such as naming staff on PSF or referral documentation. This section has also been referred to the Practice Handbook which we are unable to comment on.

10. Families need training and information on the policy – they have not had the experience of more low level incidents going to the HSE. This has proved upsetting and worrying for some family members who may be fearful of consequences despite reassurance from the agency. There are no formal guidelines on if and when family members should be informed and many feel that their name should not be going to the HSE without their knowledge or right of reply. The National Safeguarding Office needs to provide centralised documentation to include rights, data protection and adherence to GDPR.

11. The current documentation needs to be revised as it is neither an investigation tool nor a simple notification tool but a combination of approaches. The administration load is high and yet hospitals have received no extra resources to cope with this and/or taking on the DO role. A matrix or guidance tool for thresholds need to be developed. The draft policy does not include any sight of the proposed new documentation and again is a major concern in terms of an adequate response/submission.