Introduction to Group Providing Feedback

The Irish Association of Social Workers (IASW) Special Interest Group on Ageing (SIGA) provides a professional forum for social workers working with older persons in a variety of settings to promote the highest standards of professional practice while advocating for continuous improvement in service delivery. Given the nature of healthcare service delivery, while SIGA members work with older persons, our members also work with adults of all ages.

SIGA welcomes a policy that promotes the human rights, empowerment and protection of ALL adults, who for whatever reason, at a point in time, do not have the capacity to protect themselves from harm. Indeed the fact the "*Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures"* (2014) was a Social Care Division Policy was a major source of concern to social workers, a concern that was raised via IASW structures with the National Safeguarding Office in 2016 and 2017. SIGA similarly welcomes the change in terminology from "vulnerable adult" to "adult at risk of abuse" as inclusive and non-stigmatising.

This SIGA feedback on the "*Draft HSE Adult Safeguarding Policy 2018*" was compiled following the analysis of submissions from social work representatives working with older and younger adults across primary care, integrated care, medical, rehabilitation and residential care settings. Those who provided feedback include a retired member of Safeguarding and Protection Team and a current Designated Officer in a social care service setting catering for older and younger adults.

The contributors providing feedback on this draft policy were: Caroline O Donoghue, Helen Holohan, Martina McGovern, Anne O Loughlin, Deirdre Mc Nally and Aisling Coffey. The feedback was analysed and collated by Aisling Coffey.

Section1: Introduction

1.1 Fourth Paragraph

- List the members of the Review Development Group, their roles and in what capacity they were participating in the Group, perhaps as an appendix.
- List the members of the governance and technical writing group.

1.2 Practice Handbook & Documentation Suite – Publish and Seek Consultation

In the introduction and indeed referenced six times throughout the "*Draft HSE Adult Safeguarding Policy 2018*", much of the complexity within which the policy will be operational, such as issues in respect of consent, capacity and non-engagement, the relationship between the policy and Trust in Care and the transfer and discharge of patients and service users between acute and community settings is deferred to the publication of the Practice Handbook.

Bearing in mind that the Practice Handbook has been mooted since 2015, SIGA would call on the HSE to publish this draft handbook now and similarly seek consultation at this point in time so that those providing feedback can fully understand the operational implications of this draft policy.

Otherwise the feedback the HSE will receive on this policy will only ever be partial as those providing feedback have no overview of the Practice Handbook and therefore do not have a full overview of the operational implications of the policy. Indeed seeking feedback on a policy which refers to a handbook that has not been made available for public viewing, could be construed as disingenuous.

Aligned with this issue, is the fact the documentation suite associated with this draft has not been made available for feedback either. This raises the same issues as outlined above.

1.3 Fifth Paragraph

- *"The HSE recognises that the adult safeguarding roles and responsibilities, as set out within this policy, will need to be aligned to the variety of existing organisational structures and reporting relationships as part of the implementation plan".*
- There is vagueness within this sentence as to the implementation of this policy. The policy would benefit from some concrete detail on how roles and responsibilities within will be aligned with existing organisational structures and reporting relationships across service settings.

1.4 Referencing the term Social Work / Social Worker

- It is puzzling that in the introduction and indeed throughout the policy the term social work / social worker does not feature.
- The history of the Elder Abuse Service and functioning of current Safeguarding and Protection Teams is referenced, but there is no reference to the profession that staffed these teams over the past 11 years.
- It has been acknowledged by the HSE that social workers are the professional group that hold the experience and expertise in assessing, managing and responding to allegations of abuse in respect of adults and children, yet reference to the profession is absent.
- Indeed the recent research commissioned by the HSE Safeguarding Office "*Adult Safeguarding Legislation and Policy Rapid Realist Literature Review"* finds that "*whilst professionals identifying and responding in the first instance to suspected harm or abuse can vary, in the majority of models, social workers take the lead in investigating"* (Donnelly et al, 2017: 129). This occurs in Scotland, England, Northern Ireland, Nova Scotia and In British Columbia (Donnelly et al, 2017).

Section 3: Glossary

- Definition of "*Adult at Risk of Abuse*": It is unclear why this definition is not in the glossary, albeit in page 10.
- It would be helpful to cross reference the definitions and categories of abuse are outlined in appendix 1 in this section.
- Consider fully listing the individual appendix headings in Table of Contents, as the appendices contain valuable practical guidance for healthcare staff.
- After defining self-neglect it may be helpful to cross reference with the *Position on Self Neglect* as outlined in appendix 1 page 52

- There is a need to develop a self-neglect policy as referenced in this document. The current 2012 *HSE Policy and Procedures For Responding to Allegations of Extreme Self-Neglect* is outdated from an operational perspective, for example referencing the role of the Senior Caseworker, a role which no longer exists. There needs to be clarity about the organisational arrangements and the location of strategic responsibility for self-neglect including lack of self-care; lack of care for one's environment; and refusal of services that would mitigate risk of harm.
- In defining abuse, the most commonly used definitions of abuse internationally (Action on Elder Abuse, WHO, INPEA, etc) include "*relationship of trust*". Relationship of trust is defined within the glossary as a standalone definition and is not referred to again throughout the policy.
- The definition of abuse as "*understood to mean abuse by a third party*" is unclear around the issue of abuse perpetrated by strangers, including crimes such as burglary, financial scams, and distraction burglary. This needs to be clarified. The term "*by a third party*" is vague and will lead to difficulty for those referring concerns unless clarity is provided, which is usually through the use of terminology referencing "*relationship in which there is an expectation of trust".*
- It is positive to see there is a definition of Safeguarding and Protection Team which highlights their specialism and enshrines their central role in the coordination of responding to concerns of abuse - *"a HSE specialist team who have a central role in the co-ordinated response to concerns of abuse regarding adults at risk*"
- Safeguarding Assessment and Safeguarding Initial Assessment – what is the difference between these assessments?
- Person Centred Plan and Personalised Care and Support Plans – it is unclear what the difference between these two plans are. It would be beneficial to use just one term referencing the best possible plan for the adult at risk
- Footer page 5 references the Withholding Evidence Act 2012. The contributors towards this feedback are not familiar with this Act and query if this is meant to reference the Criminal Justice (Withholding of. Information on Offences against Children and Vulnerable Persons) Act 2012?
- Safeguarding Protection Plan – is the addition of the word protection necessary here? Is this not a safeguarding plan as per the current operational *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (2014)? There are a large number of HSE and HSE funded employees that have learned about the function of safeguarding plans since the publication of the 2014 policy. Unless there is a strong argument for changing terminology, existing known and used terminology should continue in order to minimise confusion and ensure the smoother implementation of the "*HSE Adult Safeguarding Policy 2018*".

Section 4: Purpose

- Paragraph three which outlines the safeguarding focus is quite clear. It is notable that **"investigating**" abuse is not referenced as this is not the role of the HSE but the role of the Gardaí. At times there can be confusion in this respect.

- The last sentence in this section states: "*For the purposes of this policy, adults at risk of abuse have given consent to receiving safeguarding support and intervention or are deemed to lack decision-making capacity in this regard".* What does this mean? Does it mean that the policy does not apply to adults at risk of abuse or actually experiencing abuse who decline safeguarding support and intervention? If so, this needs to be clarified and stated clearly.
- Aligned with the previous point, all staff members need to be cognisant of the fact that some adults at risk of abuse or experiencing abuse may have difficulty (a) understanding that they are being abused and (b) asserting their wishes in respect of their predicament for a variety of reasons. These difficulties may present as non-engagement.
- Navigating this complexity, balancing risk management and self-determination, while remaining cognisant of requirements under the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012, the Assisted Decision Making Act 2015, the Children First Act 2015 (in the case where children may be affected by adult abuse) and the HSE Consent Policy, is a role reserved for a highly skilled professional and is a role that has always been central to the social work profession.

Section 5: Scope

- We welcome the clarity that this policy applies to all HSE and HSE funded services.
- Most importantly we welcome the fact the policy applies to <u>ALL</u> adults, both service-users and adults who may not be using a service, who for whatever reason at a point in time, do not have the capacity to protect themselves from harm.
- The policies would benefit from explicit clarity on where nursing homes and home care agencies stand in respect of the policy as they are HSE funded, but not section 38 / 39.

Section 6: Values and Principles

- This section is laid out and explained very well, particularly the "*what it means for me*" which gives a real sense of what these values means for service-users.
- Page 15 Point 10: *The adult at risk of abuse should have professionals already known to them involved in the management of the safeguarding concern, where possible.* It is imperative to ensure that the adult <u>actually wants</u> these known professionals involved in the management of the safeguarding concern and that the adult's right to confidentiality is balanced with safeguarding duties. For example the adult experiencing abuse may be known to dental, optical, audiology and a variety of other services, but may not want these professionals to know highly sensitive information in respect of abuse they have experienced.

- Aligned with the point above, the reference to "*involved in the management of the safeguarding concern"* needs some clarification. Heath and social care professionals from a variety of professional backgrounds can be a support and act as advocates for the adult at risk of abuse, if that is the adult's wish, but may not have the skills nor competency to actually manage the safeguarding concern safely.
- *Professionals already known* to the client are not a requirement for any other health or social care response. An adult enters hospital for specialist treatment and do not KNOW the professionals they are going to receive a service from in advance. Will this value be used to deflect responsibility for safeguarding onto those professionals in the community, who by virtue of their large caseloads, *know* the largest number of adults in their working communities.

Section 7: Safeguarding Adults at Risk of Abuse Process

7.1 Role of Safeguarding and Protection Teams (SPTs)

- 7.1 describes the role of Safeguarding and Protection Teams (SPTs) in terms of support and advice giving, with exception of complex concerns, direction from the Chief Officer or adults unconnected to an existing service.
- This quite limited role appears contradictory to the definition of SPTs which highlights their specialism and enshrines their central role in the coordination of responding to concerns of abuse - *"a HSE specialist team who have a central role in the co-ordinated response to concerns of abuse regarding adults at risk*".
- The role of SPTs in the direct management of cases or not, needs to be made explicit in this policy. Similarly the expectation of other healthcare professionals in the assessment and management of abuse needs to be made explicit.
- The reference to complex concerns needs clarification as different professionals will operate differing thresholds for categorising concerns as complex.
- The IASW, in its 2016 feedback to the National Safeguarding Office, noted inconsistencies across the country in how SPTs operate and in particular whether they provide direct assessment and intervention in response to community setting referrals or whether there is an expectation that community-based professionals conduct this assessment and provide the intervention in these settings. In the 2016 IASW feedback it was referenced that clarity on the role of SPTs teams could be achieved in the form of Standard Operating Procedures.
- The management of current abuse concerns in social care service settings under "*Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures"* (2014) is quite clear and this clarity needs to be replicated in community settings, acute hospital settings, mental health settings, etc in this "*HSE Adult Safeguarding Policy 2018*".
- Inconsistency and confusion can be counterproductive to the highly necessary collaborative and effective working relations among professionals that an adult at risk of abuse requires to be safeguarded.

- In section 7.1 and throughout policy it refers to the SPT providing advice and guidance. The policy wold benefit from clarity on the situation where the service seeking the advice does not agree with advice received and do not action same. What are the governance implications here for both the SPT and the service / professional who sought advice? For the SPT to genuinely provide expert advice, all member of the SPT would need to be senior experienced social workers with a wealth of direct safeguarding experience.

7.2 Responsibilities of ALL Staff

- The Draft Policy states: "*It will continue to be the responsibility of all staff and services to take necessary action to ensure the protection and welfare of adults at risk of abuse".* This sentence is unclear as to the roles of ALL staff; whereas section 8.3 of this policy clearly outlines the responsibilities of ALL STAFF.
- Not ALL STAFF will have the skills, knowledge, experience or competency to manage / respond to a safeguarding concern beyond what is listed in section 8.3.
- The assessment, management and coordination of a response to abuse has been a HSE recognised social work role and was similarly referenced in "*Protecting Our Future" (2002),* the publication which lead to the establishment if the HSE Elder Abuse Service.
- Indeed the recent research commissioned by the HSE Safeguarding Office "*Adult Safeguarding Legislation and Policy Rapid Realist Literature Review"* finds that "*whilst professionals identifying and responding in the first instance to suspected harm or abuse can vary, in the majority of models, social workers take the lead in investigating"* (Donnelly et al, 2017: 129
- In section 7.2.1 the policy refers to the staff member raising a concern but does not state who they raise that concern to, albeit the line manager is referenced in appendix 2.

7.3 Data Entry Requirements

- Data Entry Requirements are referenced in 7.2.2 and 7.2.3.
- This needs explanation. Is the data entry requirement determined by each setting or is there a specific national standard all services should be compliant with?

7.4 Drafting of the Safeguarding Protection Plan

- The policy states on page 20, *"At the conclusion of the initial assessment, if it is deemed to be a protection from abuse concern, an immediate Safeguarding Protection Plan will need to be drafted. The implementation of this plan in stage 3 is undertaken with due regard to the will and preference of the adult concerned".*
- Surely both the drafting and implementation of the safeguarding protection plan will take due regard to will and preference of the adult concerned?

- This paragraph reads in a way that the professional drafts the plan and THEN considers the will and preference of the adult when attempting to implement it. This is contrary is all forms of best practice and contrary to the working assumption of social workers that the adult is the expert in respect of all aspect of their own life.
- On page 20, the draft policy states: "*The Safeguarding Co-ordinator should undertake or ensure that any Safeguarding Protection Plan in place is completed and implemented within an appropriate timescale*". The policy needs to define appropriate timescale.
- Reference to ongoing review of Safeguarding Protection Plans is welcome as this is very necessary and can be de-prioritised in the face of competing demands.

7.5 Splitting of Stage 2 Safeguarding Initial Assessment and Stage 3 Analysis and Planning in terms of Process

- There is a blatant disconnect between these two stages.
- The structure of the policy suggests the outcome of the assessment is determined before the social worker analyses the situation and creates a plan.
- When a social worker is working with an adult at risk of, or actually experiencing abuse, data gathering informs the assessment. Simultaneously the social worker is both analysing the quality of the data received and what that data means to form their assessment. The assessment includes the views of, and is completed in partnership with the client, where the client can partake. The assessment informs the plan of intervention, which is jointly agreed with the client, where the client can participate in this planning process. Then the social worker evaluates the planned intervention to see if the goals identified at assessment have been achieved.
- The splitting of assessment from analysis in the draft is difficult to understand from a practitioner perspective.

7.6 Splitting of Stage 2 Safeguarding Initial Assessment and Stage 3 Analysis and Planning in terms of Roles / Responsibilities

- Aligned with the above issue is the fact that stage 2 and stage 3 may be completed by different professionals, who may not even be of the same discipline.
- Any registered professional will have issue with drafting a plan based on another professional's assessment. This presents a governance and accountability ambiguity and represents unsafe practice.
- Best practice dictates that a social worker conducts their own assessment, planning, intervention and evaluation of a client's needs and is therefore fully accountable and answerable for their individual practice.
- To quote the HSE: "*Each health professional/HSE employee is accountable for their practice. This means being answerable for decisions he/she makes and being prepared to make explicit the rationale for those decisions and justify them in the context of legislation, case law, professional standards and guidelines, evidence based practice, professional and ethical conduct*" (HSE Procedure for developing Policies, Procedures, Protocols and Guidelines, 2009).

7.7 Spelling / Use of Language

- 7.2.1 states "*A possible safeguarding concern can be noted by a HSE employee or employee of a HSE funded service providers"*. Should this read service provider not providers?
- 7.2.2 Page 19, 9th bullet on page states "*A non-safeguarding and protection from abuse concern. In some circumstances information received may indicate a care planning concern or other service issue which. This should be formally communicated to the relevant manager*". Need to delete the word "which" or complete the sentence.
- Second last paragraph page 19 states "*It should be formally recorded by the Safeguarding Co-ordinator whether there is a care planning or protection from abuse concern or not, and what timescales are anticipated for further information to be gathered and collated*". This sentence is unclear, particularly "*care planning or protection from abuse or not*".
- Language deviations in section 7 may lead to confusion, particularly at the time of introducing a policy with such a broad scope. There needs to be consistency of language throughout to enhance clarity. Two examples of varying use of language are:
    - (a) last paragraph on page 19 states "*Following analysis, if the matter is deemed not safeguarding…" This would be more consistent if it read "if the matter is deemed a non-safeguarding and protection from abuse concern*".
    - (b) Section 7.2.2 the last sentence on page 20 states "*A Safeguarding Protection Plan initiated at the Initial Safeguarding Assessment Stage (Stage 2)…*" This would be more consistent if it read "*Safeguarding Initial Assessment stage*".

  This feedback may seem fastidious but it is in the interests of accurate policy implementation that these points are made.

Section 8: Roles and Responsibilities including Competency Requirements

8.1 Difference Between Care Issues and Abuse

- Section 8.4 states that all staff should be aware of the difference between care issues and abuse. This is a complex area and it is often very unclear. The policy would benefit from some elaboration in this area, perhaps in an appendix.

8.2 Duplication of Roles between Lead Manager for Safeguarding and Safeguarding Coordinator Role

- Section 8.4.1 and 7.2.3: Duplication of roles between Lead Manager for Safeguarding and Safeguarding Coordinator role. While reading that in some setting this may be a combined role held by one person, in a setting where there are two separate roles duplication of responsibilities can mean that neither role completes the task on the assumptions the other role will. Examples of this duplication include notifications to external personnel such as HIQA, TUSLA, GARDAI, Incident and Risk Management Reporting, etc

8.3 Lead Manager for Safeguarding

- Who does the policy envisage will assume these roles in various service settings, such as acute hospitals, primary care centres, etc? The policy would benefit from this clarity

8.4 Safeguarding Coordinator Role

- Sections 7.2.3 and 8.4.2 outline the Safeguarding Coordinator Role. Tasks / roles here include interviewing the service user about abusive incidents, convening and chairing case conferences, coordinating the response to abuse, mobilising those resources required to safeguard the adult. These are social work roles and should be named as such.
- Who does the policy envisage will assume these roles in various service settings, such as acute hospitals, primary care centres, etc? The policy would benefit from this clarity

8.5 Initial Assessment Role

- Section 8.4.3 of the policy states that "*there should be an adequate body of staff trained to be able to gather information on any safeguarding concern, to establish if grounds for concern exist, and consider if a Safeguarding Protection Plan needs to be implemented. This assessment ensures the immediate risk of abuse to an adult is appropriately managed*".
- It is very important that there is an adequate body of trained staff available to collate initial information on the concern arising and take immediate steps to safeguard an adult from further harm, particularly for periods when the Lead Manager for Safeguarding and Safeguarding Coordinator are not on duty and there is an immediate risk of abuse to an adult.
- This sentence refers to staff who are trained. Is the HSE planning on running such a training programme to ensure staff are competent to conduct and initial assessment role?
- See 8.6 for further feedback on this Initial Assessment Role.

8.6 Competency level at Safeguarding Initial Assessment

- Section 8.4.3 states that "*The skills, knowledge base and professional capacity to carry out a Safeguarding Initial Assessment would normally be present and be within the scope of practice of a wide range of qualified Health and Social Care Professionals (HSCPs). The skills and knowledge required at this initial assessment stage include a professional capacity:*
    - *To gather and analyse information*
    - *To link with other professionals*
    - *To communicate with service users*
    - *To understand the context, risks and nature of potentially abusive interactions*
    - *To complete a Safeguarding Initial Assessment form*"
- While many HSCPs have the skills, knowledge base and professional capacity to gather and analyse information, to link* with other professionals and to communicate with service users, they do not necessary have the skills, knowledge base and professional capacity to understand the context, risks

and nature of potentially abusive interactions. These are social work roles. Social workers receive education and training to understand the context, risks and nature of potentially abusive interactions as part of their professional education.

- It is not possible to comment on the professional capacity to complete the Safeguarding initial Assessment form as it has not been published with this policy.
- *****The term "link" should be replaced with "professionally liaise for the purpose of adult safeguarding". The word *"link*" is both unclear and downgrades what is a professional task.

Section 9: Operational Flowchart

- See Section 7 Points 5 & 6.
- The flowchart within "*Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures"* (2014) was beneficial in that it prompted the reporting to Gardaí, TUSLA, HIQA, etc, at an early stage. It also prompted the staff member who holds the concern to report to their line manager and to put their concern in writing. Both of these prompts are lacking in this flowchart.
- The flowchart within "*Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures"* (2014) highlighted the need for the Line Manager, Director of Services and Designated Officer within service settings to ensure the Preliminary Screening was undertaken and all necessary actions are taken to safeguard the adult. This ensured the collaboration of the line manager and director of service in the safeguarding process. This senior management collaboration has been extremely beneficial in practice and is regretfully absent in this flowchart.

Section 10: Additional Considerations

- Section 10 requires clear and detailed guidance on notifying / communicating with the person identified as causing concern and informing them that an allegation has been made against them.
- Section 10.3 references reporting crime to the Gardai. This policy would benefit for explicit clarity on whether staff members always reports to the Gardai even in circumstances where the client states that they do not want Garda involvement. A common example relates to younger adults in abusive domestic relationships with no children. While some of these adults did not want Garda involvement, they did want other health and social care supports in respect of the abuse they were experiencing. The concern in respect of reporting to the Gardai against the client's wishes is the loss of a working relationship with that client and therefore the loss of an opportunity to build the adult's confidence and self-esteem with a view to safeguarding them into the longer-term.
- Section 10.8: The policy would benefit from HSE agreement on a minimum data set required for safeguarding documentation. It would be beneficial to remind the reader that safeguarding records can be requested under the Freedom of Information Act.

- Section 10.9 is thoughtfully written and quite helpful. It would benefit from clarity on whether consent is required to refer to SPT.
- Section 10.11 is inadequate. There needs to be explicit guidance on how these policies operate in parallel with one another and guidance on data sharing between the processes. Additionally the rights of staff members or other persons of concern to access safeguarding documentation needs to be clarified.
- Section 10.12 needs to be clear prior to attempting to implement a new policy. There have been governance queries arising to date in respect of service responsibility for monitoring and reviewing safeguarding plans when the adult at risk is discharged form hospital.
- Typos on page 33:
    - Line 4: full stop required between follow-up and critical
    - Section 10.2, second paragraph, line 3: service user(s) not users(s)
    - Section 10.2, second paragraph, second last line: comma required between assessed and investigated.
    - Section 10.2, paragraph 3, sentence 1: sentence needs clarification
    - Section 10.2, paragraph 3, sentence 2: remove full stop after process and replace with a comma

Appendices

Appendix 1: Clear and useful

Appendix 2: This best practice for staff is very helpful. Some suggested additions include:

- Talk in a safe place;
- Always include an interview alone with adult at risk of abuse, especially if person of concern is a family member;
- Ask open ended questions (include sample screening questions?);
- Empower rather than rescue – ask how they feel situation can be improved;
- Consider barriers to disclosure (e.g. shame, wanting to protect abuser) and appropriate sensitivity;
- Be aware of own emotional state and of potential biases such as clinging to initial beliefs, wanting it to turn out ok, etc (Ingredients of all Risk Assessment Models- The Practitioner (Munro, E, 1999)

- It would be beneficial to reference fact that adult abuse in prevalent is society and occurs across all groups, irrespective of age, health, race, religion, etc.

Appendix 3: Quality & Safety Oversight:

- The draft would benefit from clarity on how a decision will be made in respect of how QA oversight streams will be allocated.
- Who will be conducting this function?

- Is the 3 working day limit for the Safeguarding Initial Assessment practical in light if experiences from *Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures* (2014). While the immediate safety of the adult is paramount and nothing should delay this, it is not always possible to gather all of the necessary data to complete a safeguarding assessment in three working days. TUSLA aim to have Social Work Assessments of Child Protection and Welfare Concerns completed within 20 working days.

Appendix 5: Building Blocks for Safeguarding and Promoting Welfare Prevention: Include competent and fully trained workforce capable of identifying potential risk factors and indicators of abuse