EI16 SAFEGUARDING VULNERABLE ADULTS POLICY

1. Policy Statement

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

1.2 Epilepsy Ireland operates a 'No Tolerance' approach to any form of abuse and promotes a culture which supports this ethos and promotes safeguarding of vulnerable adults.

2. Purpose

2.1 This policy and procedure has been developed to ensure that vulnerable adults that we are in contact with in Epilepsy Ireland are protected from harm and abuse, and where abuse has occurred or is occurring, that the organisation responds appropriately

2.2 The policy and procedure has been developed to guide all workers in the organisation relating to how to respond to abuse reported by service users.

2.3 This policy and procedure meets the requirements of the HSE Section 39 Funding expectations and when read along with the HSE Safeguarding Vulnerable Adults Policy comprises of the approach of the Epilepsy Ireland.

3. Definitions

3.1 A Vulnerable Person is defined as '*an adult who is restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation. This may arise as a result of physical or intellectual impairment and risk of abuse may be influenced by both context and individual circumstances.'*

3.2 A person with epilepsy is not defined as 'vulnerable person' specifically due to their diagnosis of Epilepsy. Health Conditions do not automatically restrict a person's capacity to guard themselves against harm or exploitation, or to report such harm or exploitation. However, any abuse or suspected abuse occurring to our service users should be reported to management regardless of the definitions stated above.

3.3 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."*

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

3.5 There are several forms of abuse, any or all of which may be perpetrated as the result of deliberate intent, negligence or lack of insight and ignorance. A person may experience more than one form of abuse at any one time. The following are the main categories/types of abuse.

Types of Abuse

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

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

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

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

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

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

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

Further information relating to Abuse is included in the appendices of this policy – as outlined in the HSE safeguarding policy

4. Legislation

In the Health Act 2007 (Care and Support of residents in Designated Centres for persons (children and adults with disabilities) regulation 2013, this covers concerns relating to residential settings. Other actions are covered within general legislation.

5. Scope

5.1 This Policy and Procedure applies to all workers in Epilepsy Ireland.

5.2 It applies to all situations where abuse is apparent, suspected or disclosed to anyone within any of our services.

5.3 It applies in situations where formal health or social care services are not in place but where concerns have been raised by, for example, family members or others in relation to the safeguarding of an individual and a health and/or social service response is required and this concern has been raised with staff in Epilepsy Ireland.

6. Responsibilities

6.1 The CEO is responsible for ensuring that the organisation operates from policies an procedures which protect Vulnerable Adults.

6.2 The Director of Services is responsible for developing the policy and procedures in line with the guidance in the HSE Safeguarding Vulnerable Adults policy and ensuring staff are trained and signed off in the operations of the policy and that the policy and procedures are operated and reviewed as required.

6.3 The Designated Officer is responsible for operating all DO responsibilities outlined in the procedure. In Epilepsy Ireland the DO is the Director of Services – Wendy Crampton.

6.4 All workers are responsible for operating a zero tolerance approach to abuse in the organisation and should be familiar with and operating from the policy and procedure herein.

6.5 The Board have the responsibility of reviewing the practices of the organisation relating to safeguarding vulnerable adults via the Quality and Safety Subcommittee.

7. Further Resources

7.1 This policy and procedure should be read along with the HSE Safeguarding Vulnerable Adults 2014 which outlines all relevant aspects of Safeguarding Vulnerable Adults.

7.2 In addition the following HSE policies are relevant to this policy and procedures:

- National Standards for Residential Services for Children and Adults with Disabilities, (Standard 3).
- HSE Policies for Managing Allegations of Abuse against Staff Members
- HSE National Consent Policy
- Children First: National Guidance for the Protection and Welfare of Children
- Safety Incidence Management Policy

7.3 This policy should be read and operated in conjunction with all other Epilepsy Ireland Policies and the Staff Handbook.

SAFEGUARDING VULNERABLE ADULTS - PROCEDURES

8. Understanding Abuse

8.1 Who may abuse?

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

- **Familial Abuse -** Abuse of a vulnerable person by a family member.
- **Professional Abuse -** Misuse of power and trust by professionals and a failure to act on suspected abuse, poor care practice or neglect.
- **Peer Abuse -** Abuse, for example, of one adult with a disability by another adult with a disability.
- **Stranger Abuse -** Abuse by someone unfamiliar to the vulnerable person.

8.2 Where might abuse occur?

Abuse can happen at any time in any setting.

8.3 Accidents, incidents and near misses

Epilepsy Ireland operates an Accident Management Policy and Procedure. Where accidents, incident and near misses occur, there is potential that the service may be at organisational risk, including of safeguarding vulnerable adults, which needs to be managed. All Incidents are monitored by management to ensure that safeguarding issues are responded to appropriately.

8.4 Vulnerable Persons - Special Considerations

Abuse of a vulnerable person may be a single act or repeated over a period of time. It may comprise one form or multiple forms of abuse. The lack of appropriate action can also be a form of abuse. Abuse may occur in a relationship where there is an expectation of trust and can be perpetrated by a person who acts in breach of that trust. Abuse can also be perpetrated by people who have influence over the lives of vulnerable persons, whether they are formal or informal carers or family members or others. It may also occur outside such relationships. Abuse of vulnerable persons may take somewhat different forms and therefore physical abuse may, for example, include inappropriate restraint or use of medication. Vulnerable persons may also be subject to additional forms of abuse such as financial or material abuse and discriminatory abuse. It is critical that the rights of vulnerable persons to lead as normal a life as possible is recognised, in particular deprivation of the following rights may constitute abuse:

- Liberty
- Privacy
- Respect and dignity
- Freedom to choose
- Opportunities to fulfil personal aspirations and realise potential in their daily lives
- Opportunity to live safely without fear of abuse in any form
- Respect for possessions

People with disabilities and older people may be particularly vulnerable due to:

- diminished social skills
- dependence on others for personal and intimate care
- capacity to report
- sensory difficulties
- isolation
- power differentials

8.5 Rights of Vulnerable Persons

Adults who become vulnerable have the right:

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

8.6 Non Engagement

Particular challenges arise in situations where concerns exist regarding potential abuse of a vulnerable person and that person does not want to engage or co-operate with interventions. This can be complex particularly in domestic situations. Where an adult indicates that they do not wish to engage or cooperate with services which may provide them with essential care, where we believe the adult is vulnerable and may or may not have the capacity to make decisions, in Epilepsy Ireland, we will consider this a safeguarding issue and report it to the HSE for further advice.

It is also important to identify the respective functions and contributions of relevant agencies which include An Garda Síochána, Tusla and local authorities. Inter-agency collaboration is particularly important in these situations. We will co-operate with all other relevant agencies in a circumstance where safeguarding concerns exist.

9. Preventing Abuse and Promoting Welfare in the organisation

9.1 Building Blocks for prevention

The following are building blocks for preventing abuse from occurring and should be followed by all workers:

- People being informed of their rights to be free from abuse and supported to exercise these rights, including access to advocacy;
- A culture of zero tolerance to abuse;
- Operating confidentiality and information sharing processes as appropriate in the organisation and externally as appropriate
- Undertaking needs assessments to inform people's choices
- A range of options for support to keep people safe from abuse tailored to people's individual needs;

9.2 Risk Management

All workers should be aware of assessing and managing any risk that arise which may leave the service user vulnerable to abuse, and follow all policies and procedures of the organisation which are designed to reduce risk. Confidentiality is a right, but not an absolute right, and it may be breached in exceptional circumstances when people are deemed to be at risk of harm or it is in the greater public interest.

9.3 Common personal risk factors that workers should be aware of when working with service users include:

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

9.4 Common organisational risk factors include:

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

10. Confidentiality

10.1 To ensure protection of vulnerable service users, managing where the boundaries of confidentiality lie is very important for workers. The Epilepsy Ireland confidentiality policy guides this process.

10.2 The effective safeguarding of a vulnerable person often depends on the willingness of the people working in the organisation sharing relevant information. It is, therefore, critical that there is a clear understanding of professional and legal responsibilities with regard to confidentiality and the exchange of information. All information regarding concerns or allegations of abuse or assessments of abuse of a vulnerable person should be shared, on *'a need to know'* basis in the interests of the vulnerable person, with the relevant statutory authorities and relevant professionals

10.3 No undertakings regarding secrecy can be given. Those working with vulnerable persons should make this clear to all parties involved. However, it is important to respect the wishes of the vulnerable person as much as is reasonably practical. Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. They are not intended to limit or prevent the exchange of information between professional staff with a responsibility for ensuring the protection and welfare of vulnerable persons. It is possible to share confidential information with the appropriate authorities without breaching data protection laws. Regard should be had for the provisions of the Data Protection Acts when confidential information is to be shared. If in doubt the organisation will obtain legal advice.

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

11. Principals of working with Vulnerable Adults

11.1 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

These principals are elaborated on in the appendices of this policy.

12. Key Considerations in Recognising Abuse

12.1 Recognising Abuse

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

12.2 Early Detection

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

12.3 Barriers for Vulnerable Persons Disclosing Abuse

Barriers to disclosure may occur due to some of the following:

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

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

12.4 Considering the Possibility of Abuse

The possibility of abuse should be considered if a vulnerable person appears to have suffered a suspicious injury for which no reasonable explanation can be offered. It should also be considered if the vulnerable person seems distressed without obvious reason or displays persistent or new behavioural difficulties. The possibility of abuse should also be considered if the vulnerable person displays unusual or fearful responses to carers. A pattern of ongoing neglect should also be considered even when there are short periods of improvement. Financial abuse can be manifested in a number of ways, for example, in unexplained shortages of money or unusual financial behaviour. A person may form an opinion or may directly observe an incident. A vulnerable person, relative or friend may disclose an incident. An allegation of abuse may be reported anonymously or come to attention through a complaints process.

12.5 Capacity

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

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

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

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

12.6 Complaints

All workers in Epilepsy Ireland should handle complaints via the Complaints Policy and make service users aware of the complaints procedure if they wish to do so. Particular attention should be made by workers managing the complaints procedures to any complaint that indicates abuse of a vulnerable adult. In this case the Safeguarding procedures should be followed

13. Responding to concerns or allegations of abuse of vulnerable people

13.1 The following procedures are required to reflect the HSE policy for Safeguarding Vulnerable Adults.

13.2 In each Community Healthcare Organisation, a Safeguarding and Protection Team (Vulnerable Persons) will be available to work closely with all relevant service providers to support the implementation of the response to concerns and complaints of abuse of vulnerable persons in HSE and HSE funded services. The Designated Officer in Epilepsy Ireland will work closely with this team if a concern arises.

13.3 **Designated Officer**
Epilepsy Ireland Designated Officer (Director of Services) is responsible for:

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

13.4 All workers in Epilepsy Ireland who have a concern or a report of abuse must be immediately notified to the Designated Officer and in the event of their unavailability to the CEO.

13.5 All information relating to allegations or concerns of abuse will be subject to the conditions of the Epilepsy Ireland confidentiality policy whereby limits of confidentiality apply if:

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

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

13.7 Accurate records of concerns and allegations of abuse and any subsequent actions should be kept by the DO using HSE templates. Workers reporting abuse will have an obligation to complete written reporting procedures outlined herein.

14. Stages in responding to allegations of concerns of abuse

14.1 Stage One: Worker responsibilities and actions:

When a complaint or concern arises the worker should ensure the immediate safety of the service user and contact An Garda Siochana directly if safety is a concern. Worker then informs their own manager and the Designated Officer. The worker should provide a written report providing all relevant information as outlined below. **The form to use for this is included in the appendices.**

14.2 A concern regarding concerns or allegations of abuse of a vulnerable person may come to light in one of a number of ways:

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

14.3 The alleged perpetrator may be, for example, a family member, a member of the public, an employee of the HSE or in an organisation providing services. Abuse can take place anywhere - and might relate to our service or another service or may arise in a person's own home or other community setting.

14.4 Worker responsibilities which should be addressed on the ***same day*** as the alert is raised are as follows:

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

14.5 Listen, Reassure and Support
If the Vulnerable Adult has made a direct disclosure of abuse or is upset and distressed about an abusive incident, listen to what he/she says and ensure he/she is given the support needed.
Do not:

- Appear shocked or display negative emotions
- Press the individual for details
- Make judgments
- Promise to keep secrets
- Give sweeping reassurances

14.6 Detection and Prevention of Crime
Where there is a concern that a serious criminal offence may have taken place, or a crime may be about to be committed, contact An Garda Síochána immediately.

14.7 Record and Preserve Evidence
Preserve evidence through recording and take steps to preserve any physical evidence (if appropriate). ***As soon as possible on the same day***, make a detailed written record of what you have seen, been told or have concerns about and who you reported it to. Try to make sure anyone else who saw or heard anything relating to the concern of abuse also makes a written report.

The report will need to include:

- when the disclosure was made, or when you were told about/witnessed this incident/s;
- who was involved and any other witnesses, including service users and other staff;
- exactly what happened or what you were told, using the person's own words, keeping it
- factual and not interpreting what you saw or were told;
- any other relevant information, e.g. previous incidents that have caused you concern.
- Remember to:
- include as much detail as possible;
- make sure the written report is legible and of a photocopiable quality;
- make sure you have printed your name on the report and that it is signed and dated;
- keep the report/s confidential, storing them in a safe and secure place until needed.

14.8 Report & Inform

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

14.9 The Designated Officer (or CEO) must report the concern to the Safeguarding and Protection Team (Vulnerable Persons) within ***three working days*** after he/she has been informed of the concern. The Designated Officer must also notify Tusla ***immediately*** if there are concerns in relation to children.

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

14.11 Stage Two: Designated Officer Procedures

The Designated Officer will contact the Safeguarding and Protection team and undertake a preliminary screening process within three working days or designate another person to undertake the preliminary screening if appropriate.

14.12 The Designated Officer will complete the HSE Preliminary Screening Form and send it to the Safeguarding and Protection Team (Vulnerable Adults) for review. This must be completed within three working days of the initial concern and the actions planned to be taken should be included for S&P team to review.

14.13 Where the preliminary screening indicates no grounds for concern, this should be sent to the HSE S&P team for review.

14.14 Flow Charts indicating the HSE roles and flow of responsibilities can be found in the HSE Safeguarding Policy Document if required.

14.15 The Preliminary Screening can be undertaken by the Designated Officer, or other person determined by DO and CEO as required. The results of the Preliminary Screening will be returned back to the Designated Officer ***within 3 working days*** following the report. Additional expertise may be added as appropriate.

14.16 The Preliminary Screening will take account of all relevant information which is readily available in order to establish:

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

14.17 **Ensuring Immediate Safety and Support**

On receipt of the report of suspected or actual abuse, the Designated Officer or other person designated by them will establish and document the following:

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

14.18 Information Gathering

The Designated Officer or an appropriate staff member appointed by the designated officer should contact the person whom the concern relates to discuss consent to share or seek information. It is important to remember that in the process of gathering information, no actions should be taken which may put the person/s referred or others at further risk of harm or that would contaminate evidence. The types of information to be gathered will be dependent on the individual circumstances of the report. Accordingly, information sources will vary depending on the nature of the referrals but some examples include:

- Gaining the views of the individual referred.
- Checking of electronic/paper files to establish known history of person.
- Checking if there are services already in place and liaison with those services.
- Verifying referral information and gaining further information from the referral source.
- Considering consultation with An Garda Síochána to see if they have any information relating to the person/s referred or alleged perpetrator.
- In general, through the information gathering process, the following information should be available:
    - Name of person/s referred.
    - Biographical details and address/living situation.
    - As much detail as possible of the abuse and/or neglect that is alleged to have taken place/is taking place/at risk of taking place (including how it came to light, the impact on the individual, and details of any witnesses).
- The views of the person/s referred and their capacity to make decisions.
- Details of any immediate actions that have taken place (including use of emergency or medical services).

- An overview of the person/s health and care needs (including communication needs, access needs, support and advocacy needs).
- An overview of the person's needs.
- GP details and other health services/professionals.
- Details of other services/professionals involved.
- Name of main carer (where applicable) or name and contact details of organisation providing support.

14.19 Involvement of staff member:

In situations where the allegation of abuse arises in respect of a member of staff in Epilepsy Ireland, then the HSE Policies for Managing Allegations of Abuse Against Staff Members (Trust In Care) will be followed. Epilepsy Ireland Designated Officer will be guided by this policy to determine stages of investigation and procedures.

14.20 Involvement of a service user

In the event that the concerns or allegations of abuse identified a service user, The Designated Officer will seek appropriate advice from the HSE S&P Team.

14.21 The report of the preliminary screening will be completed by either Designator Officer, or individual given the responsibility by the Designated Officer. In either situation, the Designated Officer is responsible for determining appropriate actions and preparing a written plan for each action. The report and the associated plan is then submitted to the HSE S&P Team who may advise on other appropriate actions. Based on the information gathered, an assessment should be made which addresses the following;

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

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

No grounds for reasonable concern
An outcome that there are not reasonable grounds for concern that abuse has occurred does not exclude an assessment that lessons may be learned and that, for example, clinical and care issues need to be addressed within the normal management arrangements.

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

Reasonable Grounds for Concern Exists
A safeguarding plan must be developed to address the concerns.
The plan may include:
1. Local informal process
2. Internal Inquiry
3. An Independent Inquiry
4. Assessment and management by Safeguarding and Protection Team (VulnerablePersons).

14.23 The outcome of the preliminary screening must be notified to the HSE S&P team and actions after this point must be agreed with the HSE S&P Team. Garda Síochána should be notified if the complaint/concern could be criminal in nature or if the Inquiry could interfere with the statutory responsibilities of An Garda Síochána.

15. The Safeguarding Plan

If the preliminary screening determines that reasonable grounds for concern exist a safeguarding plan must be developed. Responsibility to ensure a safeguarding plan is developed rests with the Designated Officer and relevant staff members. In Epilepsy Ireland a safeguarding plan will be an unusual outcome as we are not a residential or day care service and have little opportunity to manage or implement a safeguarding plan. However, we will participate with developing and activating a plan related to the relevant service provision of the organisation and provide the S&P team the information required for decisions relating to safety plans to be taken further. Further guidelines relating to safety plans can be found in the HSE Safeguarding Vulnerable adults Policy and can be referred to if required. Safeguarding plans should be undertaken, implemented and submitted to the safeguarding team within 21 days. If EI are involved in implementing a plan, the Designated Officer will be the safeguarding plan co-ordinator and will be charged with implementing and reviewing the plan.

16. Protected Disclosures

Epilepsy Ireland has a protected disclosures policy which may be used if an employee reports a workplace concern in good faith and on reasonable grounds in accordance with the procedures outlined in the legislation it will be treated as a 'protected disclosure'. This means that if an employee feels that they have been subjected to detrimental treatment in relation to any aspect of their employment as a result of reporting their concern they may seek redress. In addition, employees are not liable for damages as a consequence of making a protected disclosure. The exception is where an employee has made a report which s/he could reasonably have known to be false.

17. Appendices and access to Forms

HSE forms for preliminary screening, safeguarding plans and community reporting are available with the Designated Officer in EI, and are available from HSE Safeguarding teams.

Appendix One:	Full Definitions of Abuse
Appendix Two:	Principals of working with vulnerable persons
Appendix Three:	HSE Policy for Self-Neglect
Appendix Four:	Reporting a Safeguarding concern – form for EI workers
Appendix Five:	Flow charts for Responding to allegations/concerns
Appendix Six:	Safeguarding Statement to be displayed in all services

Appendix 1

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

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

Type of Abuse: Sexual	
Definition	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.
Examples	Intentional touching, fondling, molesting, sexual assault, rape. Inappropriate and sexually explicit conversations or remarks. Exposure of the sexual organs and any sexual act intentionally performed in the presence of a service user. Exposure to pornography or other sexually explicit and inappropriate material.
Indicators	Trauma to genitals, breast, rectum, mouth, injuries to face, neck, abdomen, thighs, buttocks, STDs and human bite marks. Service user demonstrates atypical behaviour patterns such as sleep disturbance, incontinence, aggression, changes to eating patterns, inappropriate or unusual sexual behaviour, anxiety attacks.

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

Type of Abuse: Financial	
Definition	Financial or material abuse includes theft, fraud, exploitation, pressure in connection with wills property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
Examples	Misusing or stealing the person's property, possessions or benefits, mismanagement of bank accounts, cheating the service user, manipulating the service user for financial gain, putting pressure on the service user in relation to wills property, inheritance and financial transactions.
Indicators	No control over personal funds or bank accounts, misappropriation of money, valuables or property, no records or incomplete records of spending, discrepancies in the service users internal money book, forced changes to wills, not paying bills, refusal to spend money, insufficient monies to meet normal budget expenses, etc.

Type of Abuse: Institutional	
Definition	**Institutional abuse** may occur within residential care and acute settings including nursing homes, acute hospitals and any other in-patient settings, and may involve poor standards of care, rigid routines and inadequate responses to complex needs.
Examples	Service users are treated collectively rather than as individuals. Service user's right to privacy and choice not respected. Staff talking about the service users personal or intimate details in a manner that does not respect a person's right to privacy.
Indicators	Lack of or poor quality staff supervision and management. High staff turnover. Lack of training of staff and volunteers. Poor staff morale. Poor record keeping. Poor communication with other service providers. Lack of personal possessions and clothing, being spoken to inappropriately, etc.

Type of Abuse: Neglect	
Definition	Neglect and acts of omission include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life such as medication, adequate nutrition and heating.
Examples	Withdrawing or not giving help that a vulnerable person needs so causing them to suffer e.g. malnourishment, untreated medical conditions, unclean physical appearance, improper administration of medication or other drugs, being left alone for long periods when the person requires supervision or assistance.
Indicators	Poor personal hygiene, dirty and dishevelled in appearance e.g. unkempt hair and nails. Poor state of clothing. non attendance at routine health appointments e.g. dental, optical, chiropody etc. socially isolated i.e. has no social relationships.

Type of Abuse: Discriminatory	
Definition	Discriminatory abuse includes ageism, racism, sexism, that based on a person's disability, and other forms of harassment, slurs or similar treatment.
Examples	Shunned by individuals, family or society because of age, race or disability. Assumptions about a person's abilities or inabilities.
Indicators	Isolation from family or social networks.

Appendix Two

7.3 Principles

Vulnerable persons have a right to be protected against abuse and to have any concerns regarding abusive experiences addressed. They have a right to be treated with respect and to feel safe. The following principles are critical to the safeguarding of vulnerable persons from abuse: Human Rights; Person Centeredness; Advocacy; Confidentiality; Empowerment; Collaboration. What follows here is the section of the HSE Safeguarding policy relating to these principals

7.3.1 Human Rights

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

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

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

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

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

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

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

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

7.3.2 Person Centeredness

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

7.3.3 Culture

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

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

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

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

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

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

- Management of service users money/property.
- Behavioural Management.
- Control and Restraint.
- Working alone.
- Complaints.
- Incident Reporting.
- Confidentiality.
- Bullying and Harassment.
- Personal Development to include friendships and relationships, etc.

7.3.4 Advocacy

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

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

The purpose of advocacy is to[6]:

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

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

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

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

- *"Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making".*

Access to independent and accurate information improves equality of opportunity and provides a pathway to social and other services. Advocacy needs to respond to a range of complexity, from situations that require limited involvement and intervention, to a level of complexity that requires significant intervention.

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

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

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

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

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

7.3.5 Confidentiality

All vulnerable persons must be secure in the knowledge that all information about them is managed appropriately and that there is a clear understanding of confidentiality among all service personnel. This must be consistent with the HSE Record Management Policy.

The effective safeguarding of a vulnerable person often depends on the willingness of the staff in statutory and voluntary organisations involved with vulnerable persons to share and exchange relevant information. It is, therefore, critical that there is a clear understanding of professional and legal responsibilities with regard to confidentiality and the exchange of information.

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

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

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

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

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

7.3.6 Empowerment

This principle recognises the right of all persons to lead as independent a life as possible. Every possible support should be provided in order to realise that right. Self directedness recognises the right of the individual to self-determination insofar as is possible, even if this entails some degree of risk. Abiding by this principle means ensuring that risks are recognised, understood and minimised as far as possible, while supporting the person to pursue their goals and preferences.

Future Health: A Strategic Framework for the Reform of the Health Service 2012 -2015 places a focus on a shift towards service provision in the community and a move towards mainstream services rather than segregated services. The Social Care Division of the Health Service Directorate is committed to promoting a culture of trust, respect, dignity, honest communication and positive risk management for all who receive and provide supports.

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

7.3.7 Collaboration

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

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

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

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

Appendix Three : HSE Safeguarding Policy Section on Self-Neglect

16.0 Self-Neglect

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

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

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

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

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

17.0 Definitions

17.1 Self-neglect:

- Self-neglect is the inability or unwillingness to provide for oneself the goods and services needed to live safely and independently.
- A vulnerable person's profound inattention to health or hygiene, stemming from an inability, unwillingness, or both, to access potentially remediating services.
- The result of an adult's inability, due to physical and /or mental impairments or diminished capacity, to perform essential self-care tasks.
- The failure to provide for oneself the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain.

- Self-neglect in vulnerable adults is a spectrum of behaviours defined as the failure to, (a) engage in self-care acts that adequately regulate independent living or, (b) to take actions to prevent conditions or situations that adversely affect the health and safety of oneself or others.

17.2 Groups that may present with self-neglecting behaviours.

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

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

18.0 Guiding Principles

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

19.0 Manifestations of Self-Neglect

19.1 Hygiene

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

19.2 Life Threatening Behaviour

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

19.3 Financial

Mismanagement of financial affairs.

20.0 Assessment of Self-Neglect: Key Areas

Area / Domain	Evidence of Serious/Severe Neglect
Personal Appearance: hair, nails, skin, clothing, insect infestation	Matted, dirty hair; long, untrimmed, dirty nails; multiple or severe pressure ulcers, other injuries; very soiled clothing; multiple insect infestation.
Functional Status: cognitive; delusional state; response to emergencies; Medical needs	Impaired cognition; delusional state; unable to call for help or respond to emergencies. No documentation of a health care provider; untreated conditions, appears ill or in pain or complains of pain or discomfort.
Environment	Poorly maintained- evidence of rubbish, debris; dilapidated dwelling – broken or missing windows, walls. Severe structural damage, leaking roof. Pungent, unpleasant odour. Human /animal waste. Rotting food; litter. Clutter- difficult to move around or find things. Multiple uncared for pets. Problems with electricity, gas water, telephone.
Nutrition	Nutritional deficiencies are significant. It is difficult to assess food storage, availability of food groups and expiry dates.

(Dyer et al, 2006) From Draft of the Self-Neglect Severity Scale accessed from: http://www.bcm.edu/crest/?PMID=5668

21.0 Procedures

Consider the possibility.

- Concerns regarding extreme neglect can arise for a variety of people in diverse circumstances. It is critical that one remains open to considering the possibility that a vulnerable person may not be acting in his/her own interest and that his/her welfare is being seriously compromised.
- Considering the possibility of extreme self neglect is a professional responsibility and a service to the person.
- Discuss the concerns with appropriate people and directly with the vulnerable person.
- If concerns cannot be addressed directly, they should be directed to the Safeguarding and Protection Team (Vulnerable Persons) who will assist in an assessment of the severity of the situation.

Approach

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

Assessment:

- On receiving a report of concern about a vulnerable person neglecting himself/herself, the professional/service receiving the report will begin the process of preliminary assessment.
- The Professional/Service will establish whether the vulnerable person is aware of the referral and his/her response to the person making the referral.
- The Professional/Service will consult with other health and social care professionals in order to gain further information. The focus of this preliminary process is to establish the areas of concern, i.e. the manifestations of self-neglect and the perception of those making the referral of the potential harm to which the vulnerable person and/or others are exposed.
- The Professional/Service will establish if there have been any previous attempts to intervene and the outcome of such attempts/interventions.
- The Professional/Service will arrange for an appropriate person to meet the vulnerable person to ascertain his/her views and wishes.
- The Professional/Service may arrange a multidisciplinary strategy meeting, where a decision can be reached as to the person best placed to take a lead role.
- A comprehensive assessment may need to be undertaken by a relevant specialist. This will require a GP referral. Where there is a doubt about the person's capacity to make decisions and/or to execute decisions regarding health, safety and independent living, the assessment should include specific mental competency assessment. If it is not possible to engage a vulnerable person in obtaining such an assessment, it may be appropriate to seek legal advice.

Safeguarding Plan:

- One lead person must be appointed to act as a co-coordinator of information and intervention. The lead person will arrange a full review at agreed intervals.
- The responsibility for appointment of a lead person will be with the Manager in the service or area involved.
- If the vulnerable person has mental capacity and agrees to intervention, a Safeguarding Plan will be developed in accordance with his/her wishes.
- If the person has mental capacity and refuses services, every effort is made to negotiate with the person. Time is taken to develop and build up rapport and trust. It is important to continue to monitor the person's well being.
- If the person lacks mental capacity, legal advice may be required to inform the decision making process. Decisions must be made in the best interests of the person and, if possible, based on his/her wishes and values. However, it is not appropriate to take a paternalistic view which removes the autonomy of the vulnerable person.

Review:

- The lead person will arrange a full review of the Safeguarding Plan at agreed intervals.
- The vulnerable person's situation must be kept under review, as appropriate and deemed necessary
- Family, friends and community have a vital role in helping vulnerable people remain safe in the community.
- The Safeguarding and Protection Team (Vulnerable Persons) will be available to provide advice and support as appropriate.

REPORTING A SAFEGUARDING CONCERN
(Internal Epilepsy Ireland Form)

This form is to be used by workers who have a concern regarding adult abuse and need to record a particular incident or situation that they have come across. This form must be filled out confidentially and submitted to the Designated Officer

Please outline your concerns in this box. (use extra paper if required) Details should be included as guided by the Safeguarding Policy:

Details of the person making the complaint to you:
Name:
Address:
Date of birth (if known):
Next of Kin:

Details of worker completing this form:
Name:
Position:
Date submitted to DLP:

PLEASE EMAIL THIS FORM TO THE DESIGNATED OFFICER DIRECTLY ALONG WITH MAKING A PHONE CALL TO REPORT.

SECTION FOR DLP (Designated Liaison Person) (not to be completed by worker)

Date that report was submitted:
Further details discussed with worker:

Details of decision made regarding situation and actions taken:

Decision reported back to worker:

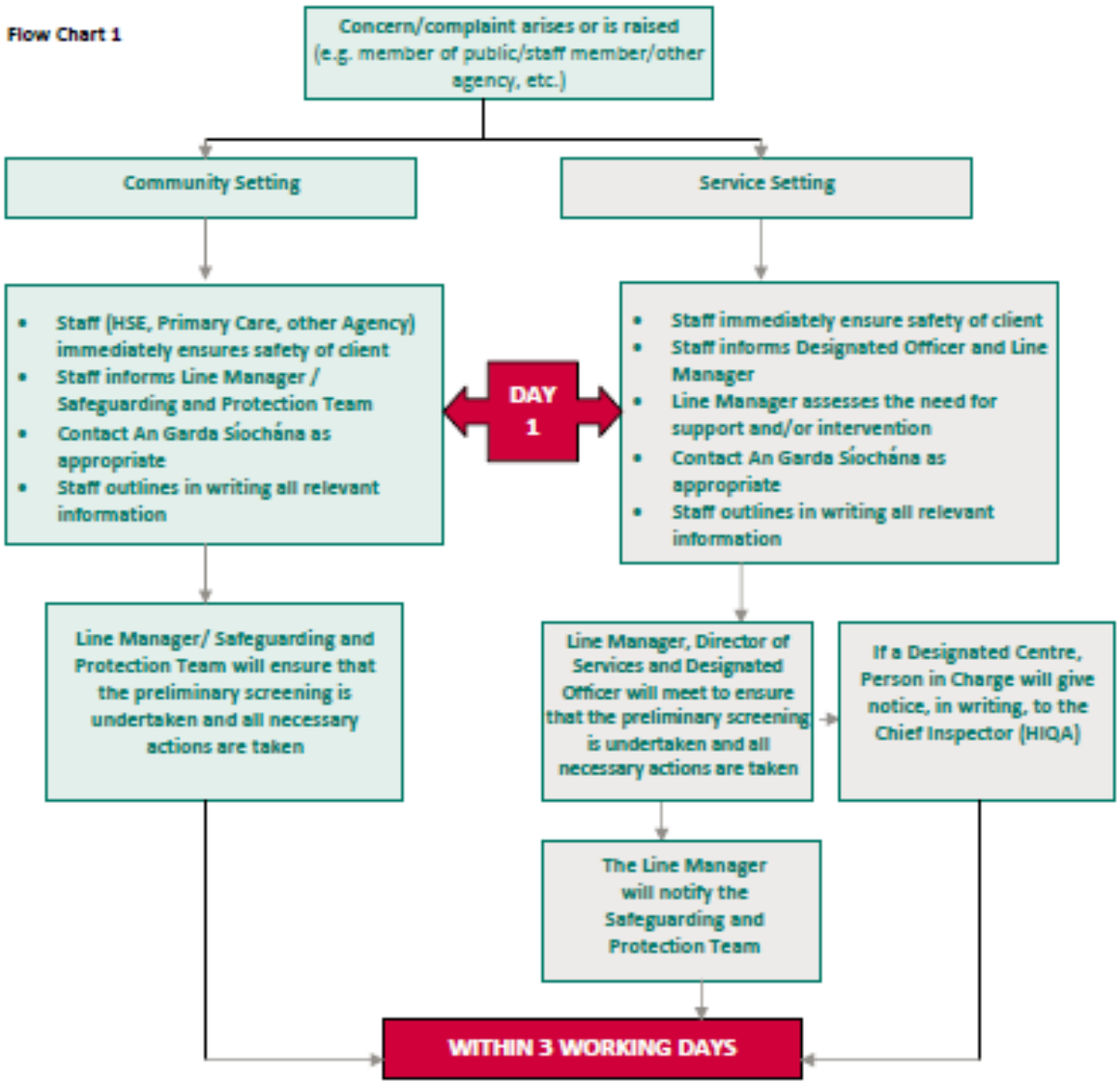
Decision reported back to CEO: (date of conversation)

This form should be kept confidentially in Head Office. No copies should be kept locally on region office sites. This report is subject to court orders / Commissioner orders where information must be disclosed and HSE requirements of information Sharing

10.0 Stage 1: Responding to Concerns or Allegations of Abuse.

Stage 1- Concern Arises.

Flow Chart 1



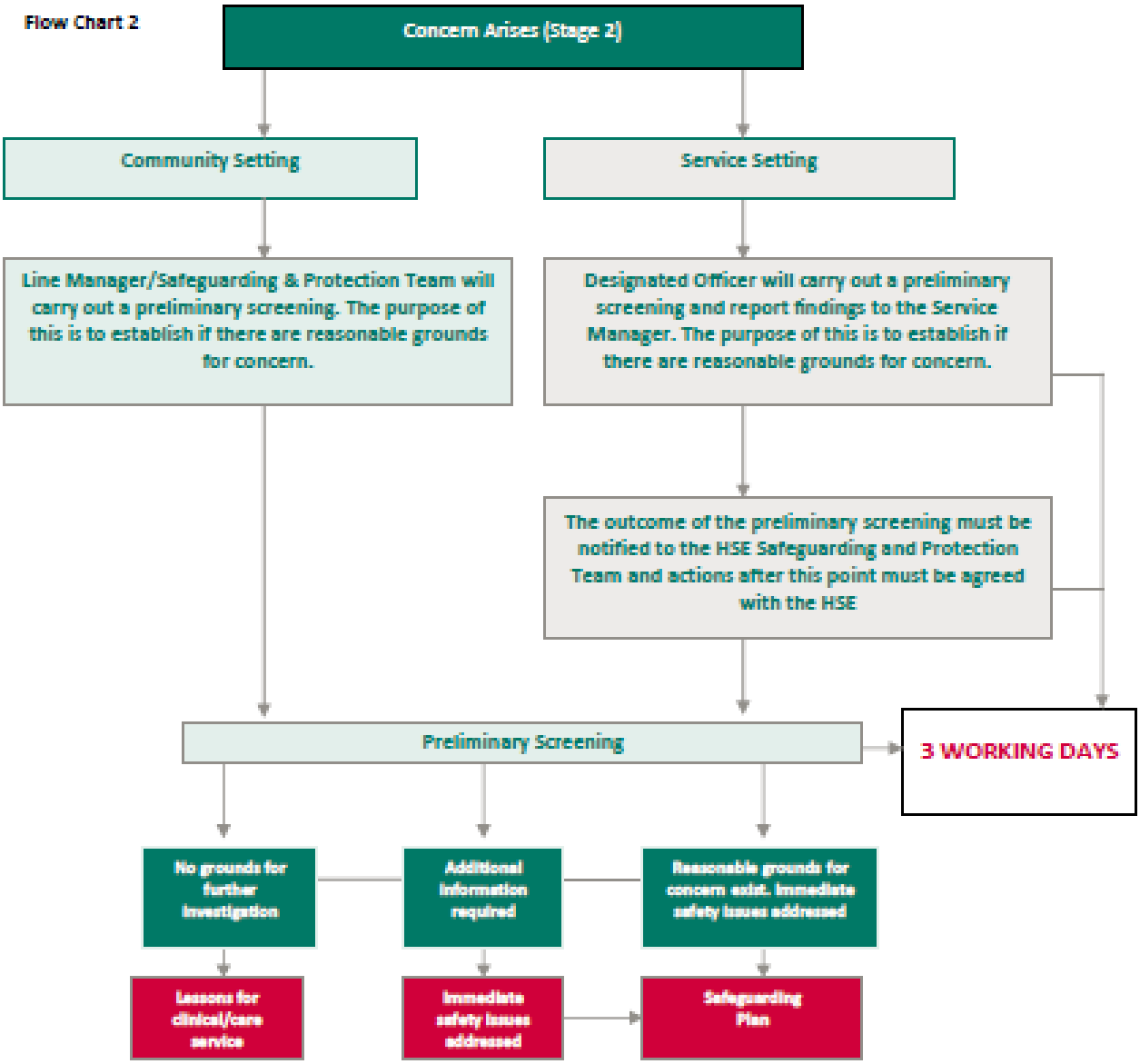
Proceed to Stage 2 - Preliminary Screening - Section 11.0

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

11.0 Stage 2 – Preliminary Screening.

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

Flow Chart 2



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

Safeguarding Policy Statement

Developing positive relationships with our Service Users is a core value in Epilepsy Ireland. Our staff understand that the very foundation on which such relationships are built is based on respect for, and dignity of, each individual. We have a philosophy of ensuring that our services are person centred and meet the needs of each individual. We support service users to advocate for their rights in society.

Abuse is a violation of that relationship and of an individual's human and civil rights. The staff and volunteers in Epilepsy Ireland are committed to practices which promote the welfare of all our service users, uphold their rights and safeguard them from harm.

We are committed to promoting an atmosphere of inclusion, openness and transparency and greatly welcome feedback from the people who use our services, their families, carers, our staff and volunteers so that we can continue to try to improve our services.

We will strive to safeguard those who use our services by adhering to the Epilepsy Ireland Policy – *Safeguarding Vulnerable Persons* – and the HSE Safeguarding Policy – *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures.*

You may contact us if you have any concerns that you or another adult you know is being or has been abused. If you would like a copy of our Safeguarding Vulnerable Adults Policy & Procedures please contact any member of staff.

The Designated Officer for Epilepsy Ireland is Wendy Crampton (Director of Services) at (01) 455 7500.

If you wish to make an external complaint about abuse you may also contact HSE services directly via the HSE complaints process – contact 1850 24 1850