Safeguarding Vulnerable Older Adults at risk – The implementation of a Link Nurse Practitioner (LNP) in Older Persons Services to educate staff and promote awareness

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Declaration Form

I hereby certify that this material which I now submit for Year 2 Change Project, MSc Leadership 2014-2016, is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.

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1.1 Introduction

_Vulnerable persons have a right to be protected against abuse and to have concerns regarding abusive experiences addressed. They have a right to be treated with respect and to feel safe_ (Health Service Executive) (HSE 2014b p 13).

Striving to provide a high quality, safe and supportive service to older adults in residential care is a consistent challenge and it is critically important as the old age dependency ratio in Ireland is expected to increase from 17.4% in 2012 to 36.3% in 2045 (Central Statistics Office CSO 2012). All residential care services, both public and private, are independently regulated by the Health Information and Quality Authority (HIQA) with a primary function to promote sustainable quality healthcare to safeguard older adults. Failure to achieve a minimum standard may result in failure to register as a service provider (HIQA 2015a). The catalyst for this organisational development (OD) project evolved when the minimum standard of staff training, as per HSE requirements, did not protect vulnerable older adults (VOA’s). The residential care facility managed by the author believed their safeguarding practices were adequate and within HSE policy when they received a report from the regulatory authority stating, _Significant improvements were required, most notably in safeguarding practices ……inspectors were not satisfied that staff demonstrated adequate awareness or responded appropriately to possible signs of abuse_ (HIQA 2015c). This created a ripple of vulnerability throughout the service as identified in reflection one (Appendix One), and it attracted much speculation and media attention (Appendix Two). The existing system of two-year mandatory training sessions had created the perfect storm. The education had been implemented, but how it was interpreted by the employee beyond a tick box system of attendance was not
evaluated. The implementation of a Link Nurse Practitioner (LNP) specifically trained in the protection VOA’s, is, therefore being introduced as an additional safeguard to enhance staff development in recognising and responding to elder abuse.

Since its inception in 2008, HIQA has influenced the most significant change ever known to Irish Health care as an independent regulator (HIQA 2008). Following revelations of elder abuse in an Irish Nursing home, Leas Cross in 2005 (RTE 2005) a catalyst for change was created. It was the recommendations from the Leas Cross investigation (Department of Health 2009) and the Health Act (2007) regulations that paved the way for the establishment of HIQA as an independent regulator. Despite the significant investment in Irish legislation, regulation and policy development (Naughton et al. 2010; HIQA 2012; HIQA 2013; HIQA 2014; HIQA 2015), the risks of elder abuse in residential care remain significantly high (Lafferty et al. 2015).

For this OD project, the author has chosen to implement a LNP in each ward in a Band 3 HSE residential facility, to reduce the risk of elder abuse through the support, education and training of staff at ward level. Face to face delivery of training is considered a superior mode of training in elder abuse (Richardson et al. 2002). This is expected to safeguard older adults by supporting all grades of staff with a consistent knowledge base to recognise, respond to, and report varying types of elder abuse. The LNP evolved from the strategic vision of the author, to grow and develop staff as individual leaders through a process of transformation (Gill 2011). However, the author understands that protecting VOA’s is multifactorial and it cannot be viewed in isolation. A depleting global Nursing resource (Dumay & Rooney 2011) and a subsequent increase in Health Care Assistants (HCA) (Irish Association of Directors of Nursing and Midwifery 2013) (Department of Health 2014) enhance the complexity. Furthermore, an increase in residents with dementia, (Downes et al.
have the potential to increase the risk of elder abuse in residential services (Naughton et al. 2012). The LNP is expected to create an awareness of the organisational culture that currently exists and shape staff practices and behaviours to prevent harm from occurring and contribute to the protection of VOA’s. However, the true prevalence of elder abuse remains largely unknown due to a lack of understanding among the general public and practitioners, in addition to no standard definition being determined (Filinson 2006). What we currently recognise as elder abuse and neglect, may extend to cyber abuse for example, through the engagement of social media. This reinforces the urgency to invest in cultures that protect our VOA’s through new initiatives as identified in this LNP project.

Chapter one outlines the organisational context, rationale and aims and objectives of the project. Chapter two explores the evidence in the literature regarding elder abuse in residential care and how the LNP might support the protection of VOA’s. Initially, elder abuse is defined to increase our understanding of the associated risk factors in residential care. Staff training and development in addition to the residential environment, are identified as factors that have the potential to reduce the possibility of elder abuse. Chapter three outlines the methodology and the HSE organisational change model (HSE 2008) is recommended for the implementation of this project. Chapter four considers the evaluation of the project using the KAMA (Knowledge and Management of Abuse) tool (Richardson et al. 2003) to assess staff knowledge pre and post implementation. The Kirkpatrick Model (Kirkpatrick 1959) will be used to evaluate the overall return on investment in each of the objectives outlined. Chapter five summarises the change project and draws conclusions on its effect on the protection of VOA’s. Finally, recommendations for future service delivery are considered.
1.2 Organisational Context

In Ireland, approximately six per cent of the population over 65 years receive residential care (CSO 2012) with over 21 per cent of residential care provided by the HSE (HSE 2014a). The student is a Director of Nursing (DON) in a 161 bedded HSE facility. This service is divided into 89 Residential Continuing Care beds and 72 Rehabilitation short stay beds. The facility is further divided into five residential wards, two rehabilitation wards and one stroke unit. HIQA regulates the residential beds and although the rehabilitation beds do not come under the remit of HIQA both services (residential and rehabilitation) are interlinked as Older Adults and staff move from one area to the other in service delivery.

While the author would argue that the majority of older people living in residential care homes receive high quality care, there is evidence to suggest that mistreatment does occur. The public enquiry into the Mid-Staffordshire report in the United Kingdom National Health Service (NHS) (Government UK 2013) and the Leas Cross report (Department of Health 2009) in Ireland identified neglect which became catalysts for change. More recently, the HIQA investigation into a residential service (Aras Attracta) in the Disability sector (HIQA 2015b) revealed further shocking revelations of abuse. Such reports have supported the need to encapsulate the protection of vulnerable adults under the Social Care division which connects the disability and older persons services (HSE 2014b).

The implementation of a LNP in each unit in the organisation is expected to prevent mistreatment of VOA’s by developing the knowledge base of all staff through regular discussion and case scenarios. Face-to-face delivery of training is considered a
superior mode of training in elder abuse when compared with the dissemination of information through other means such as printed materials (Richardson et al, 2002). The LNP will strategically equip staff with the knowledge to confidently identify and report elder abuse and this is considered a major factor in the protection of VOA’s (Fealy et al. 2014).

A recent HIQA registration inspection in the organisation identified that although staff had received HSE mandatory training on Elder Abuse, there was no evidence to suggest that this training was sufficient. An incident of abuse from staff members had occurred in the Hospital, which management was not aware of (HIQA 2015c). This triggered an investigation into the hospital's HSE safeguarding policy, procedure and practice guidelines (local and national) which were systematic and deemed appropriate up to this point. The investigation became the catalyst for change and from which the benefit of a potential role for an LNP emerged. The regulatory position will now be considered.

1.3 The Regulatory Position

HIQA are the regulatory authority for promoting standards in residential care facilities in Ireland and subsequently have the power to de-register any facility that is in serious or persistent breach of its standards (HIQA 2014). In such an event, HIQA issues a report detailing the transgressions of standards and the facilities registered provider (in this case the HSE), is given the opportunity to reflect, respond and put in place safe guards that prevent such incidents from reoccurring. The authors concern in this particular case is that such regulation identifies a breach of standards in isolation i.e. a particular event of unreported abuse in a particular residential facility.
It fails to recognise that such incidents may be the result of a systemic failure. Furthermore, an evaluation of HSE training on Elder Abuse suggested that although staff knowledge on being able to identify and report elder abuse had increased immediately after training was received, there is no evidence to suggest that this experience extended over the two year mandatory training period (Fealy et al. 2014). HIQA standard 24 on staff training and supervision states that staff should not only receive induction but also ‘continued professional development and appropriate supervision’ (HIQA 2013 p 34). The hypotheses may therefore suggest, that any such lapse in time from when staff receive training, to the time they are updated, can potentially put older adults at risk.

These National policy guidelines have adopted the HIQA Residential standards definition of Abuse 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 wellbeing, 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 (HIQA 2013 p 107).

The LNP is expected to support residents at risk of abuse by ensuring all staff are upskilled and monitored on a consistent basis at ward level. The aim and objectives of the project are now considered.
1.4 Aim and Objectives

1.4.1 Aim
Implementing a LNP, dedicated to the protection of VOA’s at ward level, is expected to support best practice by combining elder abuse training with staff development in recognising and responding to elder abuse.

1.4.2 SMART Objectives
1. Review and develop new Policy, Procedures and Guidelines (PPG) in line with best practice on the protection of vulnerable older adults (HSE 2014b) and supported by HIQA regulation guidelines (HIQA 2014) by the 1st November 2015.

2. Secure a Link Nurse to attend a HSE Train the Trainer Programme on the Protection of Vulnerable Adults in each of the eight wards by the 1st October 2015.

3. Devolve a database of staff training needs on Elder Abuse from Nursing Administration central office to each unit to maintain current records at ward level with the LNP by the 1st November 2015.

4. Identify Staff’s baseline knowledge on the protection of VOA’s through Scenario case discussion using the KAMA Tool A (Appendix Three) no later than the 1st January 2016.

5. There will be 100% compliance of staff in each ward in the receipt of at least one LNP support and development training session by the 1st February 2016.

6. There will be a 15% increase in staff knowledge identified by comparing the results of KAMA Tool A to KAMA Tool B (by the 1ST April 2016), following the implementation of the LNP training.
1.5 The Role of the Student in the Organisation and Project

The author (student) will assume the role of Project Director and will be instrumental in creating the vision for change as the implementation of the LNP is an entirely new concept. Therefore winning the support of key stakeholders (Appendix Four) by legitimising the goals of the project will be an essential requirement. It is recognised that the student will require the support of Practice and Development (P&D) staff already in the hospital to participate in the Project Initiation Plan.

The HSE change model has been chosen to help the student in implementing this change as it places particular emphasis on communicating and engaging with stakeholders (HSE 2008). Building a critical mass to support this change project from the bottom up is essential for its success, and the author hopes to achieve this through active engagement and building trust and credibility to secure the commitment of all the stakeholders. The HSE change model is considered the most appropriate model to use to create and sustain such change. The author will be responsible for the implementation of the organisational change and the evaluation of the post-project implementation.

The expected outcome of the implementation of the LNP per unit is that each staff member will be consistently supported and equipped with the appropriate skills and knowledge to identify and report incidents of elder abuse. Training records will be maintained at ward level where staff have easy access to same. Enhanced communication is expected to raise staff awareness of potential cases of elder abuse and prevent contraindicated cultures developing in the first instance through scenario analysis and general discussion. The LNP is therefore expected to be a
consistent support to staff and not just a once off mandatory training session as had been administered every two years previously.

1.6 Rationale for selecting the project

The rationale for selecting this project is considered using the PESTLE acronym (Aguilar 1967) to determine the external triggers (Appendix Five) and a SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis (Appendix Six) to identify internal triggers. Success is dependent on full stakeholder engagement and the author recognises the planning and initiation stages of the HSE change model (HSE 2008) are essential to this process. On considering the rationale with senior management in the HSE, the implementation of the LNP on the protection of VOA’s does not require ethical approval. This change project represents a formal quality improvement process to support organisational development.

1.7 Summary and Conclusion

Protecting VOA’s needs to be recognised as a systematic process. An essential part of preventing elder abuse is the use of formal training (Fealy et al. 2014) and evidence suggests that face-to-face delivery of training is a superior mode of training (Richardson et al, 2002). The implementation of the LNP is expected to provide consistent support to staff at ward level thereby supporting the National guidelines on the protection of VOA’s and the organisations HIQA requirements.
Chapter Two - Literature Review

2.1 Introduction

Findings from this literature review are presented in a narrative format, to ascertain some of the factors that may contribute to elder mistreatment in residential care. The research draws attention to the OD project, by linking the findings with the rationale for the implementation of a LNP, which potentially could become a key initiative in safeguarding VOA’s. A global review of the literature was conducted by obtaining 64 articles from the establishment of HIQA in 2008 to date. This review was condensed down to a total of 42 articles and grey literature that concentrated on the prevention of elder abuse in residential care settings and strategically focused on defining elder abuse, staff training and development and the environmental impact on quality of life issues.

2.2 Search Strategy

The bibliography assembled for this review identified mostly original documents through the following databases; CINHAL, Medline, Emerald, Embase and Google Scholar Database searches. As elder abuse is a highly emotive topic in residential care worldwide, data sources were rich which allowed the author to concentrate on the most recent articles. Hence, the search was limited to the last six years with many articles obtained within the last four years. The Grey Literature was also a rich source of data particularly in the Irish context, with the Health Amendment Act (2013) and the implementation of the National Policy on the Protection of Vulnerable Adults
(HSE 2014b). The World Health Organisation (WHO), United Kingdom National Health Service (NHS), HSE and the Irish National Council for the Protection of Older People (NCPOP) were invaluable sources of information.

Singular and combination keyword searches included; Elder Abuse, Residential Care, Staff Training/ development, Definitions (of elder abuse), prevention, detection and Quality of Life. The main themes that emerged from this search included varying perceptions of what constitutes elder abuse due to the complex evolution of defining same. Identifying the role of staff training and development in the prevention, detection and response to elder abuse. Finally, the impact of the care environment in supporting quality of life incentives to create a positive work environment, are identified in the literature as a means of preventing elder abuse. These will now be considered in greater detail.

2.3 Review of Themes

2.3.1 Theme 1 - Defining Elder Abuse

The HIQA regulations (HIQA 2014) and policy initiatives (HSE 2014b) have sought to enshrine the rights of older people in the Irish constitution. Despite such measures, elder abuse remains a relatively new and complex phenomenon (Phelan 2013). Furthermore, there has been little consensus about a definite definition (Mysyuk et al. 2013) which enhances the complexity of the issue and makes research into elder abuse inherently challenging (Wang et al. 2015).
2.3.1.1 – Early Definitions

The focus of early definitions in the 1970’s was on physical abuse (Baker 1975) and later developed within the wider context of risk factors denoting relationships of trust being broken in elder mistreatment (McMullen 2004). This view was further categorised into physical, psychological and financial abuse (Block & Sinnott 1979) which concurs with the dependency and vulnerability of the older adult. This view is shared by others, as it is widely recognised that elder abuse is a worldwide problem that occurs across many different socioeconomic cultures (Phelan 2013). Mysyuk et al (2013) state that elder abuse manifests itself in a whole range of settings and at all levels of society whichconcurs with the authors view that any incident of elder abuse should be linked to a systems-wide analysis and not be restricted to the particular location where elder abuse occurred.

As definitions of elder abuse in the literature worldwide lack consensus (Mysyuk et al. 2013), most authors concur that definitions are essential in the prevention of elder abuse. Without a clear understanding of what constitutes elder abuse, healthcare professionals are ill equipped to mitigate against it (Policastro & Payne 2014). Furthermore, effective intervention and prevention strategies are associated with clear and consistent definitions (Biggs et al. 1995).

2.3.1.2 – Current Definitions

For the purpose of this OD project, the HIQA definition (as stated in 1.3, p 11) was considered the most appropriate definition to use as it regulates the organisation and it encompasses the complexity of the phenomena. It categorises abuse into physical, psychological, sexual, financial, neglect and institutional violence which incorporates a resident’s space and the rigidity of the institution on visits and recreational activity
These categories have been expanded from the earlier definition of elder abuse (HIQA 2008) which in itself demonstrates the evolving nature of abuse and questions the need for a single or standard definition.

Mysyuk et al (2013) identified the need for such definitions to be sufficiently broad and flexible to capture different behaviours that constitute abuse in varying settings. Phelan (2009) argues if a definition is too general it does not provide clarity to health care professionals. It is therefore suggested that any definition of elder abuse needs to be specific and concrete to be useful in professional contexts’ (Mysyuk et al. 2013 p 50). This literature suggests that in the absence of a concrete definition, abusers may not recognise what they are doing constitutes abuse. Furthermore, it is suggested that with varying definitions, abuse may be perceived differently by professionals in different settings (Wang et al. 2009). The LNP is expected to mitigate against any such misunderstanding through a process of consistent training and meaningful engagement with staff at ward level.

The World Health Organisation uses a common broad definition;

*....a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person* (World Health Organisation 2016).

It goes on to suggest that elder abuse can take various forms and can be the result of intentional or unintentional neglect. Neglect is identified as a common type of abuse in residential care (Phelan 2009; Naughton et al. 2012; Drennan et al. 2012; Alon & Berg-Warman 2014; Powers 2014). Factors identified were staff burnout, low levels of job satisfaction and poor staff commitment to their organisation (Drennan et al. 2012). Another study at the same time in the Czech Republic, found that
employees most at risk of being abusers were those suffering from burnout and inadequate knowledge (Buzgova & Ivanova 2011). Intervening to reduce caregiver stress (through the introduction of the LNP) in elder abuse is identified by other authors as a factor in the protection of VOA’s (Wang et al. 2009)

2.3.1.3 – Responding to Elder Abuse

However, some authors argue that efforts to respond to elder abuse are often impeded by professional’s lack of knowledge concerning the recognition and identification of elder abuse and neglect (Almogue et al. 2010). Brandl and Raymond (2012) support this view by suggesting that elder abuse is so diverse and multifactorial caregiver stress cannot be identified as a primary cause (Brandl & Raymond 2012). This is further supported by an Israeli study that identifies elder abuse as a social problem. It considers legal intervention (such as HIQA) yielded the highest improvement in preventing harm, but the provision of supportive services (such and training and development) was most effective in the long term reduction of incidence and harm (Alon & Berg-Warman 2014).

The diverse, complex nature of elder abuse is clearly identified in the literature (Phelan 2013). Hence identifying particular causes (as opposed to systematic reviews), can have unintended consequences such as blaming the older adult, minimizing offender accountability and devaluing the response to elder abuse which in turn puts the VOA at greater risk (Brandl & Raymond 2012).

Amongst the ambiguity that exists, most authors concur that a precise definition supports health professionals to identify elder abuse (Mysyuk et al. 2013). Some literature goes further to claim elder abuse needs to be recognised as a syndrome in its own right (Wang et al. 2015). Castle (2011) suggests that all residential services
should be assessed for elder abuse deficiency within a standard functional framework that identifies internal, organisational and external factors of influence (Castle 2011). The grey literature does much to capture elder abuse within a given set of parameters (HSE 2014b) which is useful to Healthcare professionals. However, effectiveness is dependent on systems that adapt to change (Malks et al 2010) as the definitions continue to evolve. Mysyuk et al (2013) argue that definitive parameters may serve to restrict our understanding of elder abuse. Therefore recognising elder abuse as a syndrome of an ageing society is more likely to capitalise on our knowledge of it (Crome 2014).

2.3.1.4 – Understanding Elder Abuse

While much of the literature focuses on the health professionals understanding of elder abuse, this has been criticised by some authors as being paternalistic and disempowering to older adults (Killick et al. 2015 p 100). The objective of a Canadian study was to enable residents to identify for themselves what constitutes abuse from their perspective (Charpentier & Soulieres 2013). The results demonstrated a keen understanding of the imbalance of power that exists between the residents as beneficiaries and the staff as caregivers.

The literature clearly demonstrates the complexity attached to elder abuse and this according to Phelan (2013), is widely unplanned for in an ageing society. The prevalence rates among older people with dementia, for example, indicate that dementia in itself is a substantial risk factor (Downes et al. 2013). The literature, therefore, recommends a variety of approaches to ensure lasting systems of change can evolve to offer long term protection to VOA’s (Gironda et al. 2010). Strategies include integrating elder abuse content into existing training and building
relationships with stakeholders. The implementation of the LNP supports such recommendations. Staff training and development are now considered as a key function of the LNP’s prevention strategy.

2.3.2 Theme 2 – Staff Training and Development

As elder abuse is being recognised as a growing problem and a threat to healthy aging (Bond & Butler 2013), staff training and development is increasingly being recognised as an effective measure in the recognition and prevention of elder abuse in residential care (Lafferty et al. 2015). A recent evaluation of the HSE National training programme provided by staff in residential care settings every two years demonstrated effectiveness in improving the trainee’s ability to recognise abusive care giving strategies. However, this study was limited to a single point in time (immediately after the training was given). Therefore, it did not consider knowledge decay over the two year mandatory training timeframe. Furthermore, the study was limited to a cohort of nursing students which is not representative of the wider population of Nurses and other care staff (Fealy et al. 2014).

2.3.2.1 – Staff Education

Daly and Coffey (2010) examined the perceptions of elder abuse among nurses and care assistants in long term care settings, to identify if staff education increased confidence in the recognition and detection of abuse. The study recommended the use of focused elder abuse education and training of all employees (Daly & Coffey 2010) which in turn supports the OD project. Such specific education is reinforced by other authors who claimed rates of elder abuse identification were worryingly low among nursing professionals, particularly if they had longer care giving experience
(Caciula et al. 2010). Therefore, the longer the care giving experience, the greater the need to implement additional training the LNP can provide.

Alt et al (2011) concur that a lack of knowledge with health care professionals is a factor of elder abuse when reviewing the effectiveness of education programmes in recognising and reporting same. The comprehensive worldwide literature search created a consensus that increasing participant awareness through interactive teaching techniques, were identified as most impactful, particularly if opportunities for discussion and feedback were provided (Alt et al. 2011). The LNP is designed as an interactive learning process where case scenarios are identified within small groups at ward level, and differences of opinion are analysed to create further opportunities for meaningful discussion. This reduces the fear of legal retribution amongst health professionals, which is recognised by some authors as a reason for non-intervention and poor reporting (Almogue et al. 2010).

2.3.2.2 – Training and Development

However, such advances in staff training and development may not guarantee the safety of VOA’s, as the World Health Organisation (WHO) estimate that only 1 in 24 cases of elder abuse are currently reported (WHO 2016). Phelan (2009) suggests that even reported cases only represent the tip of the ice berg as for every reported case, much more are unreported. Explanations offered suggest that existing training focuses too much on detection and reporting of abuse and not enough on targeted prevention of mistreatment before it occurs (Dehart et al. 2009).

The purpose of the LNP project is to equip all staff with increased awareness and understanding of what constitutes elder abuse to enhance recognition and prevention (Alon & Berg-Warman 2014). Dehart et al (2009) support the view that
developing quality training programmes for direct caregivers is an essential aspect of
the prevention of elder abuse and neglect. This is reinforced by HIQA who state that
*each staff member should be trained in the prevention, protection, identification and
the reporting procedures for abuse, especially for vulnerable residents* (HIQA 2008, P.21).

2.3.2.3 – Effectiveness of Training.

The effectiveness of such training is largely unrecognised as elder mistreatment in
residential care remains largely understudied (Drennan et al. 2012). This may be due
to the realisation that elder abuse in residential care settings is a complex
multifactorial phenomenon and has only been subject to mandatory reporting with
the implementation of HIQA (2008). To date, there is little consistent data on patterns
of reporting and economics has been suggested as a contributing factor, particularly
in the private sector. High reporting of abuse incidents may place greater emphasis
on highlighting a poor quality service, which makes the residential service less
attractive to future residents (Griffore et al. 2009).

Specific elder abuse training and development of staff is recommended and
supported by the KAMA tool (Richardson et al. 2002; Richardson et al. 2003). The
LNP will use this tool in the OD project to develop continuous awareness and staff
vigilance. Avoidance or non-reporting is contraindicated in the regulations as elder
abuse is defined as an *act* or an *omission* in supporting residents care needs (HIQA
2014). The LNP is expected to alleviate ambiguity and reinforce to staff their
mandatory obligation to report abuse.

The effectiveness of education, staff training and development is well supported in
the literature as an effective means of protecting vulnerable older adults from abuse.
(Bond & Butler 2013; Dehart et al. 2009; Alt et al. 2011; Rosen et al. 2015). Face to face training is considered the most effective way to train when compared with other forms of training (Richardson et al. 2002), hence the implementation of a LNP in each unit. However, the literature recognises that education and staff development cannot be effective in isolation. They have to be considered within the context of establishing a caring environment that minimises the risk of elder abuse (Rosen et al. 2015).

2.3.3 Theme 3 – Care Environment

Much of the literature assumes that residential care services offer better protection from abuse for frail older people. This assumption was tested in a cross-sectional research study in Slovenia (Habjanic & Lahe 2012). The results demonstrated no statistical significance between settings as predictors of mental abuse. However, nursing home accommodation did significantly reduce the risk of physical and financial abuse of frail older adults. Although the study excluded dementia specific residents, the results support the assumption that residential services provide greater protection in some aspects of abuse (physical and financial) but not all aspects (psychological).

2.3.3.1 – Poor Care Environments

It is argued that such studies that are reliant on a participant’s response may be biased as it is known that there are many reasons why older adults do not report abuse. Reasons identified were the shame, fear, denial or lack of trust (Svavarsdottir & Orlygsdottir 2009). However, the study is significant in recognising that it is the environment and not the frail older person that can put elders at risk of abuse. This is
particularly evident where poor care environments exist and in some European
countries such as Sweden, staff are obliged to report poor conditions which
compromise an older person’s integrity or dignity (Rytterstrom et al. 2013). Such
negative working environments, according to the literature, are most likely the result
of non-competitive wages, poor benefits, high staff turnover and inadequate
education and training (Stone & Bryant 2012). Other authors identified a significant
positive correlation between staff to patient ratio and neglect in residential facilities.
The larger the facility, the higher the number of patients, the higher the staff turnover
which leads to a greater risk of mistreatment (Natan & Lowenstein 2010).

2.3.3.2 – Resident to Resident Abuse

In residential care facilities, an older person’s integrity can also be compromised by
resident-to-resident abuse (McDonald et al. 2015). This involves aggression and
violence that occurs between long-term-care (LTC) residents which can have serious
harmful consequences for both aggressors and victims. This Canadian review
attempted to create an enhanced understanding of the problem so that it could be
systematically addressed in practice. Other authors concur that frequently
environmental issues such as crowding, TV volume/ channel, room temperature and
lighting, fuelled such aggression between residents (Koehn et al. 2011). It is
therefore suggested that communal living environments in residential care can foster
conditions conducive to resident to resident abuse if the resident’s needs are not
given primary consideration (Snellgrove et al. 2013).

This highlights the need for staff and families to receive education and training to
enhance the overall protection of residents, as it is reported that victims of resident to
resident abuse were four times more likely to experience neglect from staff (Zhang et
al. 2012). The flow of knowledge guided by the LNP in each unit is expected to support families as the team continues to interact with residents and their families in daily activities. This concurs with authors that reported a significant increase in the reporting of incidents of resident to resident abuse post training when general awareness was enhanced (Teresi et al. 2013). Residents and family are further supported in residential care through advocacy groups (SAGE 2016) and resident forums that exist as an independent requirement of residential services (HIQA 2014).

2.3.3.3 – Environmental Protection of Residents.

Protecting residents from the environment goes beyond managing people and some authors suggest that *decaying service environments and cultures afford an early warning that older people may be at risk* (Marsland et al. 2015 p 111). An awareness of organisational cultures is therefore required. This is identified in simple terms as a set of basic assumptions that define the group (Schein 1992). Marsland et al. (2015) state that health care staff need to recognise the way culture can shape work practices and staff behaviours, as well as have the ability to recognise when services are deteriorating as these are strong indicators that contribute to the protection of older adults at risk. The LNP is in a unique position at ward level to recognise any deterioration in culture and to support a positive working environment. However, the same authors warn that such early indicators do not provide evidence that abuse has occurred. Instead it forms tangible evidence (to the LNP), that action needs to be taken to improve service quality which will reduce risks and decrease the likelihood that abuse or neglect will occur.

The LNP therefore supports a pro-active approach to safeguarding older adults and the United Kingdom ‘No Secrets’ safeguarding policy has reinforced the need to
move from a re-active to a pro-active safeguarding system (Department of Health 2008 p 26). However, while some actions will be clearly and widely recognised as abusive, others occupy the grey area between abuse and poor practice (Hyde et al. 2014). The LNP can make an active contribution to such grey areas in practice by establishing with staff what is expected. There is additional reassurance in knowing that the LNP is already actively working in the unit to continuously monitor and reinforce standards of care.

The literature suggests that staff members understand and interpret elder abuse in varying ways depending on experience and clinical intuition (Meeks-Sjostrom 2013). The LNP is expected to standardise interpretations and alleviate any misunderstandings. Brown (1999) identifies a key challenge for practitioners is to pinpoint the threshold of seriousness i.e. the point at which elder abuse needs to be reported (Brown 1999). HIQA and the HSE stipulate that all incidents of recognisable elder abuse are notifiable to the regulator and the HSE Safeguarding team within 3 working days of occurrence (HIQA 2014; HSE 2014b). Hence, the responsibility of staff to report incidents of abuse and adhere to HSE policies, procedures and guidelines (PPG) remains unchanged with the implementation of the LNP.

Enhancing protective measures through the implementation of the LNP should be welcomed as the old age dependency ratio in Ireland is expected to increase from 17.4% in 2012 to 36.3% in 2045 (CSO 2012). Hence the inevitable fact exists, as the world age profile increases, so does the incidence and risk of elder abuse (Clancy et al 2011). Hyde et al (2014) suggest that care quality concerning elder abuse in residential services is systematic, and it can collapse under any change to the organisations factors. The five factors identified in this research were infrastructure, management and procedures, staffing, characteristics of resident population and
culture. Therefore, the authors suggest that as ‘problem’ organisations are identified and managed (as with HIQA regulations), it is likely that the same problems will reoccur in other organisations if key contributing factors are not treated as a systemic problem (Hyde et al. 2014). With a worldwide aging population some authors are of the view that elder abuse should be expected (Phelan 2013). Therefore, residential services need to take responsibility for the prevention of elder mistreatment (HIQA 2014). The implications of the literature in harnessing this LNP project proposal will now be considered.

2.4 Implications for the Project

It is evident from the literature reviewed that abuse and neglect of older adults is multifaceted and it does not necessarily occur in residential care because of staff being intentionally abusive (Marsland et al. 2015). As elder abuse becomes increasingly recognised as a syndrome of old age (Wang et al. 2015), some authors suggest there should be focused screening of all older adults to increase awareness and reporting (Bond & Butler 2013). This reinforces the view that elder abuse is without limitations, and all older adults may be at risk depending on their circumstances (Phelan 2013). HIQA provides Irish residential services with the opportunity to report such incidents, yet it is widely recognised that what is reported only represents the tip of the iceberg (Phelan 2009). The HSE mandatory training programme on elder abuse for all staff in residential care is widely accredited with having improved the care and treatment of residents (Fealy et al. 2014). However, serious problems still exist (Drennan et al. 2012) which suggest that the scale of the problem has yet to be recognised.
Supports for direct care staff are essential (Alt et al. 2011) and in the absence of staff training in between HSE mandatory training every two years, this project sought to improve such supports with the introduction of a LNP in each ward. Such face to face support and developmental training is considered the most effective means of developing staff (Richardson et al. 2002). Such training has the potential to alleviate caregiver stress associated with the protection of VOA’s through case scenario discussion with the LNP. This is crucial for preventing and managing abuse (Wang et al. 2009). Gironda et al (2010) discovered that integrating such strategies into existing training, and customising content and delivery to learners needs, builds relationships with stakeholders. The key stakeholder is the VOA and these authors discovered that building relationships with older adults in residential care, is in itself, a safeguard for the resident as caregivers are less likely to abuse someone they care for (Gironda et al. 2010).

2.4.1 – Leadership Influences.

Having a LNP in each ward ensures that the norms, values and attitudes of the smaller units is representative of the larger organisational culture. This builds capacity from the ground up using a transformational approach (Bass & Riggio 2005) and therefore mitigates against fragmented subcultures (Mitchell & Boak 2009). Such an innovative Nurse led strategy is expected to support staff, however, as with any new OD project, resistance is expected. Resistance can apply to an individual employee who refuses to adapt to change and collectively this can apply to an entire workforce (Senior & Swailes 2010). According to the authors this can range from quiet, passive resistance (disinterest) to active resistance (vocal rejection).
Hyde et al (2014) claim the leadership style of managers shapes working environments in residential services and this is a significant factor in the protection of VOA’s. As nurses provide twenty four hour service provision to residents, they are best placed to bridge the link between residents and all other health care providers (Almogue et al. 2010). This reinforces the importance of multi-disciplinary collaboration in achieving a common goal in elder abuse prevention, and consistency in knowledge development as a critical aspect (Policastro & Payne 2014). The LNP can be empowered as leaders to provide such consistencies and report any difficulties that arise from the implementation of the project.

2.5 Summary and Conclusion

There is unanimous agreement within the literature reviewed that being adequately prepared to make decisions through enhancing staff knowledge and development, specific to elder abuse, protects VOA’s through prevention, detection, and notification. Leadership (through the LNP) is required to facilitate staff training, observe practice development and facilitate good care coordination in the prevention of harm to older adults (Stone & Bryant 2012). This, in turn, integrates the protection of VOA content, into the existing HSE mandatory training model and supports staff through consistent work engagement.

Gironda et al (2010) supports this model of learning as staff can share ideas, expertise and network in small groups, which is proven to have a long lasting impact on developing professional practice. This concurs with Phelan (2009) who states that vigilance and critical reflections on daily mundane interactions, can result in major improvements in practice and prevent elder abuse. Focusing on caregivers is
according to Powers (2014), crucial to understanding and intervening in the protection of VOA’s in residential care.

It is anticipated that the LNP will create a transparent quality care environment where ethical principles are focused on the dignity and well-being of the older adult (Buzgova & Ivanova 2011). The definitive test of the project will be in the evaluation of its implementation, to identify if it made a real difference to staff knowledge, as the literature in synonymous in stating that enhanced staff knowledge protects VOA’s.
Chapter Three – Methodology

3.1 Introduction

The implementation of the LNP evolved to combine HSE mandatory staff training, on safeguarding VOA’s, with staff discussion on case scenarios, to support effective care in the protection of older adults within the organisation. The vision for change became a requirement of HIQA, to ensure all staff were competent in safeguarding systems. Any breach of these policies had an impact on safeguarding VOA’s throughout the organisation which magnified the vulnerability of all the stakeholders as identified in reflection one. Effective leadership to create a shared sense of purpose (Roffey Park 2013) was therefore required to influence this change agenda. As a result, the management of people became the critical resource (Walley 2013) and the choice of organisational change model used to structure the introduction of the LNP became a key factor in its implementation (HSE 2008).

This chapter outlines the project application and considers the rationale for using the HSE model. Conclusions are drawn with a summary of the primary considerations that arose during the change process.

3.2 Change Process

A crucial factor in demonstrating organisational effectiveness, is an organisation’s ability to adapt to change (French & Delahaye 1996). The effectiveness of the HSE mandatory training on the safeguarding of VOA’s was a crucial factor in the implementation of the LNP, as practices following the organisation’s HIQA report
were held to question. All staff had received mandatory training, yet some practices were inadequate which identified a discrepancy between mandatory training and the reporting of elder abuse as is graphically illustrated in figure 1.
Figure 1: Graphic Illustration of LNP in Practice

Graphic illustration of the Link Nurse Practitioner (LNP), specifically trained on the protection of vulnerable older adults (VOA’s).

**AIM** – to develop staff knowledge at ward level to support best practice in the prevention, recognition and reporting of elder abuse in residential care.

- Increased knowledge via the KAMA tool = enhanced protection of VOA’s (Richardson et al, 2002)
- Reported Cases
- ‘Tip of the Iceberg’ (Phelan, 2009)
- Case scenario discussion with the LNP increases staff knowledge and awareness
- Discrepancy in practice identified (HIQA Report 2015c) – Implement LNP at ward level with specific training on protection of VOA’s (HSE 2014b)
- Mandatory Training for Residential Care staff every 2 years on Protection of the VOA’s (HSE 2014b: HIQA 2014)
This discrepancy in practice challenged the author to participate in whole systems thinking (National Health Service 2011a) and find new ways of engaging with staff at local and national level to ensure the systematic effectiveness of training on the safeguarding and protection of VOA’s could be upheld. Implementation of the LNP evolved when care staff as leaders recognised the need to supplement mandatory training services, with additional staff support, to ensure effective care delivery.

Planning is a critical component of initiating and sustaining change (Vora 2013). Clearly identifying the aim and objectives (chapter one) is a requirement in getting any change project started. Furthermore choosing the most appropriate change model enhances the chances of success (Blunden 2014). Conducting an analysis of factors relevant to the change strategy were also considered necessary to support the process (Kotter & Schlesinger 2008).

Internal and external factors are considered using the PESTALE acronym (Aguilar 1967). From this systems analysis it was identified that one way of connecting the external factors (HIQA, National agenda, political and environmental influences) with the internal triggers (organisational culture and individual staff experience) was through the development of a LNP specifically trained on the protection of VOA’s. Identifying a change model to successfully implement this new initiative is now considered.

3.3 Change Models

Change is a continuous process of confrontation, identification, evaluation and action (Paton & McCalman 2008 p 217).
Change in Irish healthcare is often unpredictable as identified in this OD project. What was considered a functional systems training on the protection of VOA’s was now held to question following the HIQA findings (HIQA 2015c). The effectiveness of the HSE mandatory training model was questioned as were the additional supports provided to staff to ensure safety in care delivery. The drivers for change, therefore, became the balance of delivering safe, high-quality service provision within cost containment initiatives that satisfy HIQA regulations and, therefore, public expectations (O’Halloran 2014). HIQA became the catalyst for this change project, but the drivers behind the implementation of the LNP, were the perceived benefits of the enhanced protection of VOA’s. The driving and restraining forces that influenced this OD are captured in the Force Field Analysis (Lewin 1951) (Appendix Seven). Such transformational change may, therefore, be more accurately considered as an ongoing learning process that cannot be categorised by the individual specific (organisational) event (Siverbo et al. 2013). Change in healthcare is ever evolving and at such a fast pace and over many systems simultaneously (Higgins 2013). The author as leader had to articulate where the organisation is now (identified unreported incident of elder abuse in a HIQA report) and where it needed to be in the future (preventing any such reoccurrence) (Senior & Swailes 2010). How the author managed this transition from one state to another is supported by the HSE change model (2008).

Lewin (1951) (figure 2) and Kotter (Kotter 1996) (figure 3) identified a process of steps that have to be followed to create successful change. These models suggest that all change needs to be managed through a process of unfreezing (shaking up or disturbing the status quo), moving (making the actual changes to move the organisation forward) and refreezing (stabilizing the new change). Both Lewin and
Kotter’s change theories identify change as a linear step by step process, where organisations have to start at the beginning and follow the process through the identified steps to achieve the desired outcome.

**Figure 2: Lewin’s Change Model (1951)**

![Lewin's Change Model](image)

**Figure 3: Kotter’s Model of Change (1996)**

![Kotter's Eight Steps of Change](image)

This reinforces the need for leaders to plan and lead change (Farkas 2013). However, as healthcare is so diverse and complex it could be argued that such a sequentially-ordered model may not be appropriate for use, and furthermore, it could jeopardise the process if the sequential steps are blocked in transition (Farkas 2013).

The implementation of the LNP required the involvement of staff as key stakeholders and this challenged the author to motivate Nursing staff to become link Nurses in the protection of VOA’s. This required the development of leaders through engagement and the HSE model was considered most appropriate for this process (HSE 2008).

3.4 Rationale for choosing the HSE Change Model

The HSE change model places particular emphasis on communicating and engaging with stakeholders (HSE 2008) and it develops leadership from within the organisation rather than the author taking direct responsibility for change (Siverbo et al. 2013). It was therefore considered the most appropriate model for use as it had the capacity to create and sustain successful change through active engagement, and by building trust, credibility and commitment (HSE 2008) with the link Nurses identified. Building a critical mass was inevitably going to be challenging within a minimalist time frame. Creating a bottom up approach through transformational leadership was considered essential to growing and developing staff interest in the implementation of a LNP at ward level. Such transformational leadership is also recognised as followership (Grint & Holt 2011) as followers can influence the attitudes and assumptions of others, to affect positively the change agenda (Appelbaum et al. 2015). Implementation of the LNP would then become a shared
responsibility among all caregivers (Moran & Brightman 2000) and not the sole responsibility of the author as leader of the organisation.

The complex nature of the organisation’s 8 separate departments challenged stakeholder engagement and communication, therefore continuous active participation as identified in the HSE model was critical to the success of the OD. Simply dictating this change through a transactional top down approach would have inevitably created resistance through a lack of engagement and understanding (Chen et al 2013). The human element of change had to be addressed (Brisson-Banks 2010) and leadership became critical to this process based on the organisations culture and values (Kotter 1996). The HSE change model supported this continuum of transformational change so that the OD project became an open ended process of stakeholder adaptation to changing circumstances (HSE 2008).

Influencing key stakeholders during the change project and monitoring their positions over time proved fruitful as identified in reflection 3 (Appendix Eight). The resistance that would not have been obvious was identified and managed successfully. Viewing such resistance in a positive light and affording it attention reduced the anxiety of staff to a functional level (Appelbaum et al. 2015) thereby allowing the project to proceed. The HSE model encourages active involvement and this resistance created an opportunity for discussion with the principal stakeholders. This socio-dynamic approach involves the quantification of human behaviour (D'Herbemont & Cesar 1998), with the understanding that negative attitudes towards change may be perfectly rational (Walley 2013). In fact, the literature states that absence of resistance is a sign of disengagement which is likely to lead to future problems (Ford & Ford 2008). This is proved correct at a later date when resistance occurred from an unexpected angle. A Nurses’ Representative Body instructed its members to
object to additional responsibilities with the implementation of the National Policy as it may place an extra burden on Nursing staff (Appendix Nine). Even though the National policy was published in 2014, it is only with its recent implementation that staff realise the level of responsibility and workload attributed to it. Fortunately, the LNP process was already embedded in the author’s organisation well in advance of this directive being issued. Furthermore, the successful engagement of staff and Representative Bodies at an early stage prevented such resistance as staff sought to support the development of the LNP for the greater good of protecting VOA’s.

According to the literature, resistance shows that people care as areas for refining are considered. Resistance was therefore, viewed by the author as a natural part of adapting to change (Ford & Ford 2010). The HSE change model supports this process in the planning stage (HSE 2008). The implementation of the OD will now be outlined using the HSE change model.

3.5 The HSE Change Model

There are four key stages to the HSE change model (2008) (Appendix Ten), which can be interlinked and used interchangeably, depending on where the organisation identifies itself. The four stages are initiation, planning, mainstreaming and implementation (HSE 2008). Each stage will be discussed separately. However all stages are interchangeable, and this offers greater flexibility than the previous linear models where one step has to be accomplished before the next step is considered. Higgins (2013) identifies healthcare organisations as a culmination of subsystems, and as leaders work towards change in one system, other systems may push the change back to the way it was unless the leader understands the inter-dependencies
among subsystems to keep the movement going forward (HSE 2006). This became apparent in reflection 4 (Appendix Eleven) when the author recognised the interdependency that existed between staff training and practice development. Both systems had to interlink to keep the OD project moving forward. Supporting and developing that relationship through effective leadership became critical to the success of the project. This occurred at stage one of the HSE model which will now be considered.

3.5.1 Initiation

Early planning mobilises support and identifies the organisations readiness for change (HSE 2008). This involved building a solid foundation for change with the key stakeholders as identified in the stakeholder analysis. HIQA as the regulator dictated the need for change (HIQA 2015). Therefore, the change project was well supported by the General Manager (GM) and the Chief Executive Officer (CEO). However, mobilising the governance of the project required the author to establish staff development opportunities associated with the LNP. Two staff from P&D coordinated the LNP training while the author as leader created the vision for change with staff that were actively supportive of this development. Nursing staff who chose to be involved as LNP’s recognised this as an opportunity to expand their knowledge and experience. A series of meetings took place to plan and identify this process following which a pathway for the initiation of a LNP (Appendix Twelve) was stabilised. The existing organisational policy on the protection of vulnerable older adults (Appendix Thirteen) was also updated at this time.

Step 1: Preparing to lead the change.
Brainstorming (Osborn 1963) was a method used to support this process with the existing staff. This advanced to root cause analysis (Lord & Smith 2014) (Appendix Fourteen) to identify how existing practice on the protection of VOA’s could be improved upon. Both of these methods best supported team collaboration and involvement while simultaneously generating a large volume of ideas (Feeney & Murphy 2011) in three short sessions. The author as facilitator listened to staff views so that a clear understanding of the organisation’s readiness for change could be established. The results of the root cause analyses allowed staff to visualise the areas that required change. From this, it was quickly established that enhancing the training and development of staff at ward level was a critical component in supporting the protection of VOA’s.

As mandatory HSE training was already implemented the concept of a LNP to support such training through case scenario discussion and real life experience was established. It was agreed that integrating a LNP into existing practice development was achievable. Furthermore, such face to face on site training through informal discussion is strongly supported in the literature, for enhancing the protection of VOA’s.

Identifying if the implementation of the LNP would achieve the desired outcome of supporting best practice was further explored using the Five Whys approach to ‘dig deeper’ (Feeney & Murphy 2011).

1. Why change the current system of training on the protection of VOA’s when it meets with the National standards (HIQA 2014)?

The efficacy of National mandatory training has not been fully tested. Although delivered to staff every two years as per HSE requirements, the follow up on the
effectiveness of training beyond a tick box system, remains outstanding within the organisation.

2. **Why test the efficacy of the current mandatory training?**

To identify if it is truly effective (or not) in the protection of VOA’s. The HIQA report identified deficiencies and this needs to be fully addressed.

3. **Why implement a LNP to support staff development?**

A LNP is identified in each unit to support staff development at ward level. They are uniquely positioned to test the existing system to identify its effectiveness. The KAMA tool A will be used to identify staff knowledge after mandatory training but in advance of LNP training to establish the effectiveness of the National HSE training programme. The KAMA tool B will be used to identify staff knowledge after the LNP face to face training to identify if staff knowledge has improved as a result of the implementation of the LNP.

4. **Why implement additional face to face training for ward staff through the LNP?**

- To establish a system of support for staff at ward level.
- To monitor the protection of VOA’s consistently.
- To ensure that all staff are fully compliant with their responsibilities in practice.
- To create a proactive approach to the protection of VOA’s.

Following these methods of engagement, agreement was reached among all stakeholders that the LNP should proceed on a six month trial basis. The OD timelines were therefore established in accordance with the Gantt chart (Appendix
Fifteen). Hence the vision for change was established which led to successful planning and development.

3.5.2 Planning

Planning reinforces the initiation stage by building a critical mass in support of change. It involves stabilising the shared vision for the future as the change process becomes more visible to the stakeholders as levels of communication and involvement increase (HSE 2008). Key factors such as employee morale, involvement, empowerment and managerial support are critical to success at this point (Abdallah 2014).

Step 2: Building commitment.

Building commitment, required the author to understand the organisations culture, as it is the culture of an organisation that defines the environment in which work has to be done, and outcomes achieved (Schein 1992). Organisational culture is defined as a shared system of meanings (that) dictates what we pay attention to, how we act and what we value (Trompenaars & Hampden-Turner 1997 p 13). Hence, as leader the author understood that organisational culture runs deep and without an understanding of what is involved culture can eat into strategy (Gill 2011) and quickly sabotage or ignite a project pending the leadership skills applied. Creating a shared sense of purpose (Roffey Park 2013) through a series of initial team meetings was successful in mobilising key stakeholders. The meetings initially evoked anxiety, and this led to a level of resistance from P&D, who expressed concern with regards the appropriateness of training LNP’s under the existing HSE Train the Trainer programme on elder abuse. A new programme was in the process of being established under the new guidance document Safeguarding the Protection of
Vulnerable Adults (HSE 2014b). However, this was waiting to be delivered at National level. Clarity was sought to continue with the existing HSE training until the new training was fully established. This gave the P&D officers the reassurance they needed and enhanced the organisations readiness for change through a process of questioning rather than direct resistance (Appelbaum et al. 2015).

Having the P&D facilitators on board gave full consideration to the organisations culture as P&D understood the people and the hospital systems. This awareness of organisational culture helped to shape work practices and staff behaviours as well as the ability to recognise a deteriorating environment. Armed with this level of knowledge P&D sustained positive engagement throughout. It was very much the participation of P&D that influenced the change in behaviour as the author became part of the process and not directly involved in leading it (Kotter & Schlesinger 2008). Three initial meeting were held to mobilise the stakeholder's and time invested at this point prevented issues arising at a later date.

Representative Bodies were identified as stakeholders in the initiation stage and were therefore included in the discussions. As this was a training and development programme, some staff argued the need to involve such representation. However, the author suggested that central to the project was building the commitment of staff. This proved invaluable when resistance was identified as per reflection 3 and unexpectedly from the Irish Nurses and Midwife Representative directive. This directive offered a real threat to the implementation of the LNP if published earlier. However, the LNP was already well established in the organisation by January 2016. Furthermore, staff Nurses through active engagement viewed the LNP as a means of support and not a threat. The detail of change will now be determined.
Step 3: Determining the detail of the change.

Once the vision for change was embedded in the stakeholders, the detail of how the change might proceed had to be considered. Following the development of the Gantt chart, it was regarded a strategic necessity to establish networks of accountability that would sustain the quality improvement initiative on a continuous basis (Fulmer et al. 2000). Clinical governance through the establishment of the LNP became an important aspect of this process as it promoted an integrated approach towards management (McAuliffe 2014) and the protection of VOA’s. It is well recognised that staff who work in an environment of greater accountability and clinical quality promote high standards of care where inputs, structures and processes are continually reviewed to achieve higher outcomes in service delivery (Som 2004). It was therefore agreed that expressions of interest would be sought in each unit for the development of the LNP from Staff Nurse level upwards. This allowed all Nursing staff the opportunity to understand the LNP development from an integrated and process oriented perspective (Abdallah 2014). Furthermore, it afforded them the opportunity to progress with a management initiative in their respective area. This required the author to fully engage with staff (as outlined in the initiation stage) and use a transformational approach (Burns 1978) to create a continuum of change where LNP’s could be identified and developed as leaders. Process mapping (Appendix Sixteen) was used to facilitate this process (NHS Institute for Innovation and Improvement 2013).

Process mapping was chosen by the author to present clearly a visual diagram of the sequence of steps (Lord & Smith 2014) required by the LNP to implement the change agenda. This implementation plan will now be considered.
Stage 4: Developing the implementation plan.

Organisational readiness for change cannot be underestimated, and Lewin (1951), and Kotter (1996) state that upsetting the current state of play to create an alternative vision for the proposed change allows change to be embraced effectively. Some literature suggests that individual and organisational readiness for change is based on a solid foundation of mutual trust and respect (Pope 2013). As the author was new to the organisation, building such relationships became a key factor in the stakeholder engagement process.

The author supported this process by empowering staff to make their decisions and involving them in options for consideration. This enhanced their sense of ownership, and it afforded them the opportunity to map the entire process through the system of process mapping. This visual diagram allowed the stakeholders to fully appreciate and understand the process to be followed and the outcomes to be expected. The LNP was central to this process, and they became recognised as leaders that would champion the OD project with the support of P&D and the author as project facilitator. This created a sense of ownership among all the stakeholders where trust was already fostered and implementation could begin.

The process map became the implementation plan. Tight timelines were involved to implement the OD project and review within six months. However, the excitement of the project began to take hold as the coalition for support was strongly cementing. This in itself was a victory, and it allowed a positive momentum to be established as the LNP’s recognised the benefits of the project. This created a sense of ownership and pride which in turn encouraged other staff to participate further. The merits of such active participation cannot be underestimated as without same, genuine buy in
is challenged, and sustainable change unlikely (Armenakis & Harris 2009).

Celebrating these smaller wins and fitting them into the larger vision for change (Kotter 1996) became an acquired leadership attribute for the author. The implementation of the LNP will now be considered.

3.5.3 Implementation

*Step 5: Implementing the change*

Once the LNP’s received their certificates of training, it was time for the OD to go live. At this point ensuring the LNP’s were consistent in their approach with the staff was important as the literature stated that effective intervention is dependent on coherent and consistent strategies (Biggs et al. 1995). This required the LNP to consider what the HIQA definition of elder abuse entailed and to ensure that staff fully understood same.

Training had to be consistent, and the KAMA tool was considered appropriate for this purpose through interactive engagement with all grades of staff (Richardson et al. 2003). Such interactive face to face training in small group sessions was best supported in the literature, as the most efficient type of staff training and development. Furthermore, the KAMA tool involved discussion on a simulation of case scenarios that could be easily applied and understood in a residential service. Such interactivity incorporated reflection and critical thinking specifically for frontline staff. This would ensure that all employees had a full understanding of elder mistreatment beyond a theoretical level and in addition to the National two yearly requirement. Using the HSE Train the Trainer programme to train the LNP also maintained a level of consistency as all LNP’s were formed with the same programme and by the same trainers. The literature supports this model in
residential care facilities as it focuses on how to identify mistreatment and take action appropriately (Fealy et al. 2014). As a lack of knowledge is established as a consistent factor in the incidence and poor reporting of elder abuse, using the LNP to support the development of staff knowledge in a proactive way is expected to be an effective means of protecting VOA’s through acquired knowledge.

LNP’s were supported through two team meetings with P&D and the author. It had already been established that the KAMA Tool A was going to be used to measure staff knowledge in advance of the LNP talking through each case scenario. This had a dual benefit of assessing the knowledge of staff post-HSE mandatory training and pre-LNP training to identify a baseline. To ensure records of mandatory staff training were up to date and correct all mandatory training records were devolved from a central office to each ward manager at a local level. The onus of responsibility to keep these records up to date became a staff responsibility as all staff were aware of their mandatory requirements. This supported the OD project as all staff were up to date with their HSE mandatory training on the protection of VOA’s in advance of the LNP training.

This LNP training involved using the case scenarios from KAMA tool A to create discussion among staff and identify solutions to the cases presented. Ward scenarios and issues were also discussed informally. All staff had to sign in for discussions so records of staff attending could be maintained. It was agreed that all staff would have the KAMA tool A returned by the 10th of January 2016 and staff training would go live once KAMA tool A was completed. LNP’s were asked to instruct staff to complete KAMA tool A in advance of training and without assistance so a true reflection of their current knowledge could be established.
By the 1\textsuperscript{st} March, it was expected that all staff would have a minimum of one case scenario discussion via the LNP and that this would contribute to their knowledge base and safe practice on the ward. It would also give staff the support they needed on a daily basis with the presence of their identified LNP on site. By the 31\textsuperscript{st} March, it was expected that all KAMA tool B responses would be returned and compared with KAMA tool A responses to identify if the objective of a 15 per cent (\%) improvement in staff knowledge could be achieved by attending, at least, one LNP session. 15\% was chosen as a conservative estimate from one LNP session, with a view that three sessions per annum may enhance staff’s knowledge by up to 45\%.

Initially the LNP’s reported feeling nervous about the implementation of training, but with the standardised process already established, they were able to clearly articulate what was expected of them. They understood fully that their role was one of encouragement, support and development of staff at ward level. It would not interfere with the hospital policy that had already been reviewed and adapted to include the implementation of the LNP.

Once any initial concerns were alleviated from the example in reflection 3, the change filtered through the organisation without delay. All LNP’s were conscious of the deadlines and anxious to perform well. They were fully supported in their training efforts through P&D and they quickly gained confidence in their approach. Their ability to understand the diverse interest groups and power bases within their wards was paramount and that gave them a level of political astuteness. Being politically astute required the LNP to understand the climate and culture in their unit and identify how this culture fits into the national agenda (HIQA requirements and Safeguarding policy) (National Health Service 2011b). LNP’s were, therefore,
encouraged to build commitment with the staff in their units that were supportive of the change, and feedback any issues or resistance to P&D. Knowing their organisational culture to this extent was essential to the success of the OD implementation. Furthermore, it enhanced a positive environment which was recognised in the literature as an effective means of reducing the risk of elder abuse pro-actively. Sustaining this new way of working will now be considered.

3.5.4 Mainstreaming

This is the final stage of the HSE change model, and it challenges the author to integrate the LNP role so that it can become a sustained change within the organisation.

Step 6: Making it ‘the way we do our business’

Continued and comprehensive efforts to ameliorate elder abuse are fundamental to enhancing the quality of older people’s lives in Ireland (Phelan 2013 p. 184).

Mainstreaming becomes a very important process of recognition and adaptation to support best practice in the protection of VOA’s in residential care. Supporting the LNP’s through their growth and development as team leaders became an important part of the mainstreaming process. This was managed through open communication with P&D and regular on site meetings to discuss any issues or concerns. As some wards had more capacity than others P&D supported the role of the LNP by running an additional training session in areas where one LNP felt compromised as identified in reflection 5 (Appendix Seventeen). To reduce the risk of burnout, this LNP had to be supported and due consideration needs to be given to implementing a second LNP in the same unit if the OD project is deemed successful.
Maintaining accurate records identified staff attending LNP training and it also highlighted those in need of attending. As the discussions were informal they became a way of working that was not considered stressful or in addition to an already busy schedule. It very quickly became incorporated as a support to staff through P&D as the LNP was well known and trusted by existing staff. This respectful relationship between staff member and LNP allowed the process to flourish as the tension that previously existed in relation to the organisations HIQA report started to evaporate. Staff members now felt supported in their duty of care to the resident and the element of fear was replaced with a sense of shared responsibility to maintain best practice at all times.

Step 7: Evaluating and learning

Evaluating and learning from the way this OD process has been implemented is ongoing and this will be discussed further in the next chapter. For the purpose of evaluating the use of the HSE change model during the implementation, consideration has to be given to the fact that each of the four steps discussed is an evolving process i.e. never truly closed before moving to the next stage.

This continuous commitment is required by staff to protect VOA’s, and this has never been more topical with the media reports and recent policy developments. The shared learning from this project highlighted areas of best practice and areas for improvement about the questions delivered in the KAMA tool. The HSE change model supported the need to keep pace with such developments in a way that allowed any stage of the OD project to be updated and amended as per requirements. For example the KAMA A answers were analysed so that poor areas
of practice were identified for specific training per ward as required. Figure 4 confirms the average knowledge per question from KAMA A results.

**Figure 4: Average knowledge per question (KAMA A)**

![Average % Per Question KAMA A](chart)

This review provided information that identified the needs of staff which in turn allowed the LNP to fulfil that knowledge requirement strategically.

### 3.6 Summary

The HSE Change model (2008) supported the transformational development of staff through the implementation of the LNP rather than the author taking direct responsibility for change. Change, therefore, became a process that unfolded through the interplay of multiple variables, such as culture and political astuteness (National Health Service 2011b). Improving standards of care through the training
and development of staff, by the introduction of the LNP, reduced unjustified variations in care to create a standardised approach to the safety and wellbeing of VOA’s.

The team approach developed strategic thinking and purpose, and it promoted safety in service delivery through an organisational culture continuum (Carney 2011). The HSE model, therefore, devolved the responsibility for change downwards creating greater accountability and autonomy at all levels throughout the OD project.

This shared accountability and duty of care to the protection of VOA’s in the organisation became the driving force that contributed to staff striving to support best practice. The HSE change model (2008) was the vehicle that translated vision into action and inspired ordinary people to do extraordinary things (Vora 2013). The outcome of the OD project will now be evaluated.
Chapter Four – Evaluation

4.1 Introduction

Evaluation is the final process and an essential part of a change project as it helps an organisation to understand the outcome and impact of a particular intervention (LNP), as well as feeding forward a cycle of further change initiatives (Hodges 2008). Ovretveit (2002) defined evaluation as *judging the value of something by gathering valid information about it in a systematic way and by making a comparison* (Ovretveit 2002 p.11). The same author identifies various types of evaluation in healthcare. These include programme feasibility assessment (carried out to decide if a change project should be implemented or not); process evaluation (carried out at the early stage of the change programme); outcome (carried out at the end stage of the change project); action evaluation (carried out to seek feedback from stakeholders). This can involve the collection of quantitative data (provides numeric information on how many, how often and the average response rate) and qualitative data (provides information on what worked during the change project, how the project was useful or what factors may have influenced success or failure) (Zaccagnini & White 2011). A mix of both is demonstrated in this evaluation.

In general terms evaluation has been defined by the WHO as *the systematic examination and assessment of the features of an initiative and its effects in order to produce information that can be used by those who have an interest in its improvement or effectiveness* (WHO 1998 p. 3). This supports the view that evaluations determine the *value or worth* of a healthcare initiative against an acceptable standard (Green & South 2006). This is the concept associated with the implementation of the LNP in this OD project, as to achieve a higher level of
knowledge among staff on the protection of VOA’s, according to the literature, supports best practice. Evaluation methods and tools are now considered.

4.2 Evaluation Methods and tools

Evaluation in training, development and education is well established and dates back to 1930 (Joyce 2010). More modern approaches suggest countless different evaluation models all with their own pros and cons. The Kirkpatrick evaluation model (Kirkpatrick 1959) has been chosen to evaluate the implementation of the LNP as it has been used extensively for evaluating education programmes (Yardley & Dornan 2012). It is an outcome based model that provides a clear framework for analysing educational programs. Primarily it consists of four levels; reaction, learning, impact and results with a fifth level being added later by Philips to measure return on investment (Philips 2003) (Figure 5). The constituents of this model and analyses of each level will be considered with the aim and objectives of this OD project. Initially, the method of data collection is discussed using a combined approach of quantitative and qualitative analysis.
4.2.1 Qualitative data collection

Qualitative data was used at the end of the OD to gather information on what worked well during the change project, what improvements could be made and what factors influenced the project from the participants (staff) and the LNP perspective. A small sample size was used to gather this information using a targeted questionnaire (Appendix Eighteen) where critical reflection and honesty were encouraged. A favourable response was received (Appendix Nineteen).

4.2.2 Quantitative data collection

Quantitative data was provided using the KAMA tool where each question was given a numeric response depending on the information (knowledge) supplied by the staff member. This was considered an equitable and transparent system of analysing the replies received as the total, or part of, the numeric value stated on the tool was
applied depending on the answers supplied. The rationale for choosing the KAMA tool is considered.

4.3 Rationale for using the KAMA tool

The KAMA (Knowledge and Management of Abuse) tool was specifically designed by Richardson et al (2003) to measure the participant’s knowledge and ability to recognise elder abuse by using a case scenario vignette – based questionnaire. This according to the authors was deemed most appropriate for use with all grades of staff as participants could easily relate to the simulation of care questions identified. The KAMA tool is well recognised in the literature as being an effective means of measuring participant’s knowledge on elder abuse (Richardson et al. 2003). This type of face to face discussion in small groups was considered the most effective means of increasing knowledge in healthcare staff on the protection of VOA’s ahead of other forms of education (Richardson et al. 2002). To prevent training fatigue the tool consists of two parts; KAMA A and KAMA B.

The purpose of using the KAMA tool in this OD project was two - fold. KAMA A was used to identify the baseline knowledge of participant’s in advance of the LNP being implemented. However, this baseline knowledge also served to identify if knowledge decay existed among staff within the last 6 months of participants being in receipt of mandatory HSE training. Once the LNP was implemented KAMA B was used to identify if staff knowledge on the protection of VOA’s had increased by at least 15 per cent following a minimum of one LNP session. The staff were positive in their feedback on the use of the KAMA tool; *Case studies very helpful – it gave me more confidence that I would know how to deal with similar situations* (Appendix Nineteen). This provided staff with the opportunity to reflect and progress learning
through real life discussion on particular relevant case scenarios. The use of the KAMA tool with the implementation of the LNP therefore provided a safe opportunity for staff to grow and develop as identified by staff members; *The LNP is always on hand to answer questions, to monitor the staff in their interactions with residents: Doing the questionnaires keeps me sharp and observant of my own behaviour.* Such a model of case vignette learning is described in the literature as a very powerful learning experience (Gironda et al. 2010 p. 358). The KAMA tool was therefore considered best placed to support staff development in recognising and responding to elder abuse. Any increase in staff knowledge identified, according to the literature, supports the enhanced protection of VOA’s. The objectives will now be evaluated using the Kirkpatrick model.

### 4.4 Evaluation using the Kirkpatrick model

Kirkpatrick is an outcome based model which forms a clear framework for the analysis (Ferris & Collins 2015) of the objectives identified in chapter one. However, learning outcomes such as motivation and knowledge base are not considered (McNamara et al. 2010). It could be argued that the KAMA tool itself can identify these areas of staff development as the higher the KAMA tool scores, the greater the staff knowledge and motivation towards achieving the right answer. The Kirkpatrick model has also been criticised for assuming that there is a linear association between educational programs and outcomes (Sufflebeam & Shinkfield 2007). In contrast, evaluation needs to be recognised as an evolving cycle of core values where goals, plans, actions and outcomes are continuously evaluated (Sufflebeam 1983). Despite the limitations of sequentially moving from level one to level five in the Kirkpatrick model, this process was deemed appropriate for use in evaluating the
objectives of this OD project as the implementation of the LNP was primarily a training and development initiative.

4.4.1 Level one – Reaction

Reaction evaluation is how participants feel about the training or learning experience (Kirkpatrick 1994). The goal is to measure the staff reactions to the implementation of the LNP. This was achieved by firstly creating the landscape in which the LNP could become established. As this was a new initiative, supports had to be put in place to allow the process to begin. The implementation was helped by completing a review of the existing PPG concerning the training on the protection of VOA’s as recommended nationally (HSE 2014b). Following this review (20th September, 2015) a new PPG was agreed and implemented at organisational level on the 31st of October 2015. Objective one was achieved.

This included the development of the LNP role following a series of consultations with the principal stakeholders as guided by the planning stages of the HSE change model (HSE 2008). Expressions of interest were sought for the LNP role and these were established in each of the eight units by the 31st October 2015. To become recognised trainers in the prevention of elder abuse, each LNP received the HSE Train the Trainer education programme on the Protection of VOA’s on the 22nd of September 2015. This specialised training allowed them to practice as established trainers for the HSE. Therefore, objective two was complete.

The LNP supported the development of staff training needs on the protection of VOA’s in each unit by maintaining staff training records at ward level. Existing records were devolved from a central office in Nursing Administration and a new training folder was organised at ward level for each of the eight units. This reassured
the LNP that all employees on the ward were accounted for, and their individual training needs were easily identified. The training folders were established by the 1st November 2015 which completes the third objective.

Furthermore, it allowed for the reaction of staff to be more easily identified as all employees were requested to comply with the KAMA tool and the implementation of the additional training resource (LNP). From the completion of KAMA A, it was recognised that 88% of ward staff were compliant. Comparing the response rate of two random wards a 78% compliance rate is identified with KAMA A and a lesser 55% compliance with staff completing KAMA B (Figure 6). The average return on investment of organisational compliance is therefore 71%.

Figure 6: Staff response rates

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total Direct Care Staff</th>
<th>Date</th>
<th>Response KAMA A</th>
<th>%</th>
<th>Date</th>
<th>Response KAMA B</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>St ELZ</td>
<td>18</td>
<td>01/02/16</td>
<td>20</td>
<td>111*</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>St J1</td>
<td>24</td>
<td>01/02/16</td>
<td>18</td>
<td>75</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>St J2</td>
<td>20</td>
<td>01/02/16</td>
<td>23</td>
<td>115*</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>St STP</td>
<td>19</td>
<td>01/02/16</td>
<td>18</td>
<td>95</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>St CLR</td>
<td>36</td>
<td>01/02/16</td>
<td>20</td>
<td>55</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>St OLV</td>
<td>30</td>
<td>01/02/16</td>
<td>29</td>
<td>97</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>St END</td>
<td>14</td>
<td>01/02/16</td>
<td>11</td>
<td>79</td>
<td>03/04/16</td>
<td>9</td>
<td>64</td>
</tr>
<tr>
<td>SRU</td>
<td>22</td>
<td>01/02/16</td>
<td>17</td>
<td>77</td>
<td>03/04/06</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>TOTAL</td>
<td>183</td>
<td>01/02/16</td>
<td>156</td>
<td>88%</td>
<td>03/04/16</td>
<td>20</td>
<td>55%</td>
</tr>
<tr>
<td>END &amp;SRU</td>
<td>36</td>
<td></td>
<td>28</td>
<td>78%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Although this falls short of the 100% compliance anticipated from **objective five**, it is well above the average 30-40% response rate for internal surveys (Surveygizmo 2016). Furthermore, it assures the facilitator that 88% of staff had additional elder abuse training which they would not have received without the implementation of the LNP. This may broadly suggest a favourable acceptance by staff and reasons identified for a lower response rate to KAMA B were staff absenteeism and time constraints due to the evaluation deadline attached to the completion of this project. Therefore the analysis of KAMA B was restricted to two random sample wards as opposed to the eight units identified initially.

4.4.2 Level two – Learning

Learning evaluation is the measurement of the increase in knowledge before and after (Kirkpatrick 1994) the implementation of the LNP. This is easily identified in the KAMA tool by comparing the results of KAMA A and KAMA B. The KAMA B results per question are significantly higher (Figure 7).

**Figure 7: Comparing KAMA A and KAMA B results**
**Objective six** stated that one LNP session, would deliver a return of a 15% increase in staff knowledge. As already suggested, this was a conservative estimate as over the course of a twelve month period two more sessions had the potential of increasing staff knowledge by 45% in total. However, the average return achieved following one LNP consultation for the purpose of this project was greater than 41%. This increase in knowledge signals the success of the project (Figure 8).

**Figure 8: Staff knowledge per ward**

![Percentage Score Per Ward](image)

Although the results of KAMA B are limited to two units due to the time constraints of this evaluation, the results remain significant. The average level of knowledge over the eight units shows a minimal variance of 12% with KAMA A which justifies a smaller sample size being used for comparison with KAMA B.

Creating a targeted approach to KAMA B is therefore generalised as an organisational average score. Kirkpatrick (1994) recommends that determining the
learning, needs to happen directly after the training to determine if knowledge and skills have improved. However, in this OD project the knowledge decay of the HSE mandatory training (received six months previously) was apparent from the lesser results in KAMA A. Furthermore, the implementation of one training session via the LNP significantly enhanced an increase in knowledge by 41% as determined in the results of KAMA B.

4.4.3 Level three – Behaviour/ Training Transfer

Behaviour evaluation is the extent of applied learning on the job (Kirkpatrick 1994). This is identified by changes in behaviour and a greater understanding of what constitutes elder abuse. The literature is unanimous in its findings, an increase in staff knowledge on what constitutes elder abuse substantially supports the protection and safety of VOA’s. The KAMA tool has successfully identified an increase in staff knowledge and further time is needed to review the impact on practice. One means identified was in the reporting of potential allegations of elder abuse (Appendix Twenty). From the 1st October 2015 to the 1st March 2016 the number of reported cases has increased to 10 in comparison to 3 cases reported from the previous six months. This signifies an increase of over 300% in staff awareness offering enhanced protection to the care of VOA’s.

4.4.4 Level four – Results

Results evaluation is the effect on the organisation or the environment (Kirkpatrick, 1994). The goal is to establish if the implementation of the LNP has led to outcomes that contribute to a well - functioning organisation. As demonstrated in level three an increase in the degree of reporting is a clear indication that staff have generated an enhanced awareness of what constitutes elder abuse. The feedback from the quantitative questionnaire further magnifies the level of security and openness
created at ward level as staff can openly communicate their concerns in a culture that supports them and without fear of retribution. The resident is central to any discussion forum and creating that sense of urgency to protect VOA’s is reinforced in the use of the HSE change model (HSE 2008).

4.4.5 Level five – Return on investment

Restitution on investment can only be anticipated (Appendix Twenty One) as the potential return on creating a safe, secure environment with an educated workforce that adhere to best standards cannot be underestimated. This prevents against potential distress and anxiety caused to residents and their families. From an organisational perspective, it supports the active protection of VOA’s through constant vigilance and the education of interchangeable staff as the only constant remaining is the VOA. This promotes quality and safety in the protection of VOA’s and it prevents the adverse publicity and risk of litigation associated with elder abuse.

4.6 Summary

Evaluation is the only means of establishing if an intervention has worked or not (Green & South 2006). From the results demonstrated in this evaluation, it can safely be concluded that the implementation of the LNP increases staff knowledge and awareness on the protection of VOA’s as identified using the KAMA tool. The limitations of the KAMA results are acknowledged due to time constraints in having this preliminary result available for discussion. However the significant increase in staff knowledge speaks for itself. Discussion and conclusion concerning this outcome will now be established.
5.1 Introduction

_Elder abuse is a multifaceted problem that requires interdisciplinary prevention and intervention strategies_ (Policastro & Payne 2014 p.12).

This project demonstrates the need to develop new ways of thinking to protect VOA’s in residential care. The evaluation is clear. The implementation of a LNP does improve staff knowledge and awareness in elder abuse when combined with case scenario group discussion at ward level. After a minimum of one session, it is evidenced that staff knowledge has increased by 41%. Raising staff awareness on the protection of VOA’s is expected to safeguard residents as research suggests that a low level of awareness among staff, results in failure to recognise elder abuse, and a reluctance to report same (Almogue et al. 2010).

Based on the literature reviewed, this chapter focuses on the strengths and the limitations of the project. The implications of change on the organisation and recommendations for future improvements will be discussed. Finally, conclusions are drawn.

5.2 Strengths and Limitations of the Project

5.2.1 Strengths of the project

The strength in this OD could be attributed to the high level of accountability associated with the protection of VOA’s in the organisation among all the stakeholders. Had the stakeholders not recognised the urgency associated with this responsibility, then attempting to address the initial issue detailed in the
organisations HIQA report (HIQA 2015c), would have proved a far greater challenge. It was evident to all the stakeholders that a lack of knowledge impeded the protection of VOA’s, and this concern paved the way for the implementation of the LNP.

The primary strength of the project was this simple yet highly effective idea to introduce a LNP in each ward. It was generated in the planning stages through brainstorming and root cause analysis. This created a sense of ownership among the stakeholders, and it was viewed as a means of support for staff through a process of learning and adaptation to maintain best practice in the protection of VOA’s. The LNP could, therefore, support staff with a more in-depth understanding of what constitutes elder abuse and break this information down to a level staff could understand and recognise the implications for service provision. The change project generated a safe environment at ward level where staff could explore the subject from different perspectives without fear. This established a new confidence in staff which was identified in the positive responses received in KAMA B.

Integrating a LNP specifically trained in the HSE Train the Trainer Programme on the Protection of VOA’s at ward level cultivates knowledge and stimulates interest among caregivers in association with the VOA. As one staff member reported;

   To have the programme on the ward brought issues to base. You are reminded of your surroundings, the residents and the way you treat the resident becomes more real and more important than a classroom.

This creates a new dynamic to the protection of VOA’s that is easily transferable across residential services and other healthcare sectors such as disability and social services.
5.2.2 Limitations of the project

The project is limited to the ability of the LNP to transfer knowledge and create a greater understanding among staff to support best practice. It is evident from the results of KAMA B that an increase in knowledge did occur. However, the assumption is made that an increase in knowledge and awareness automatically promotes safety in the protection of VOA’s as this is defined in the literature reviewed. Testing this assumption would take more time than this change project will allow and, therefore, changes in practice development need to be carefully monitored going forward.

A further limitation of this project was its timing in practice. The HSE implemented the National policy on safeguarding in December 2014 when it was first published (HSE 2014b) however, staff did not get the opportunity to receive training on the new safeguarding system until November 2015 (Appendix Twenty Two). Due to an extensive waiting list, only one facilitator from the organisation was allowed to attend. Had such supports been more accessible to the team during the project, it may have given additional guidance to the LNP.

5.3 Impact of Change on the Organisation

The impact of change on the organisation was demonstrated in the evaluation. A no tolerance approach was adopted and staff had the opportunity to raise grey areas in practice that may not have been identified. The LNP supported the existing governance structure which opened new channels of communication with the relevant stakeholders creating extensive buy in as the protection of VOA’s became everyone’s business.
Learning for the author occurred in the evaluation stage when it was recognised that obtaining feedback from KAMA B within the limitations of the agreed timeframe for the project was unlikely. In hindsight, the change could have more easily been tested on a small scale with perhaps no more than two organisational units. This is supported in the literature where it is advocated that change should be tested on a small scale to confirm or disprove assumptions (Senior & Swailes 2010). However, the earlier discussions with stakeholders identified the need to have consistent implementation throughout the organisation to support protection. The evaluation demonstrated that the standard of knowledge captured from the staff in the eight units (KAMA A) was relatively consistent which supported the reduction of the scale of the data collection to two units for KAMA B. The LNP continues to use KAMA B in the other wards over a longer period.

5.4 Recommendations for Future Improvements

On reflection of the lessons learned following the implementation of this change project, the following recommendations are considered for future improvements:

1. Evidence has shown that cases of reported elder abuse are far lower than anticipated cases of abuse. Factors identified in residential care settings are the lack of staff knowledge and awareness of what constitutes elder abuse. Implementing an LNP can better equip organisations to support staff in recognising and responding to elder abuse thereby offering enhanced protection to VOA’s through accurate identification and reporting.

2. It is recommended that the LNP be used in conjunction with the KAMA tool as such face to face on site discussions on case scenarios is demonstrated in
the literature as the most effective means of training for staff education on elder abuse.

3. The LNP can support the existing two year mandatory training on the protection of VOA’s by preventing knowledge decay and reinforcing best practice. Implementing the LNP has demonstrated that knowledge decay does exist (within six months of mandatory training) and using this approach enhances knowledge by 41% and therefore best practice is supported.

4. Accountability for the protection of VOA’s in residential services is every staff member’s responsibility. The effectiveness of training given to employees should be recorded in residential centres as a mandatory requirement. The KAMA tool has demonstrated its effectiveness in this regard. It is a resource that can easily be applied to all residential services. Dissemination of information to other organisations is proposed via the Abstract and Poster attached to the end of this project.

5. Finally, it is recommended that a framework of collaboration between residential services, the regulator (HIQA) and the HSE Safeguarding team should be established to raise awareness and drive prevention initiatives such as this change project. To date, each of these agencies operate as a singular entity with individual levels of responsibility in supporting the protection of VOA’s in residential units. By combining their efforts to create a streamlined common purpose in the protection of VOA’s, staff and residents can be assured of a safe quality service, with the elimination of the current silo effect.

5.5 Conclusion

This OD project has demonstrated that the complexities attached to the protection of VOA’s in residential care cannot be attributed to any one incident. Recognising elder
abuse as a syndrome of an ageing society is more likely to capitalise on our knowledge of it (Crome 2014) as there remains a lack of consensus around what constitutes elder abuse and how it should be measured (Lafferty et al. 2015). Within the context of a worldwide ageing population, elder abuse should be expected (Phelan 2013). Residential services do provide protection to VOA’s in some forms of elder abuse but this is not uniform (Habjanic & Lahe 2012) and such protection is threatened as dementia itself becomes an increasing risk factor (Downes et al. 2013).

HIQA (2014) and the HSE (2014b) recommend a no tolerance approach but to date, this means the detection of abuse is limited to re-active reports when an event potentially occurs. As demonstrated in this OD project, such reporting mechanisms can create uncertainty on what constitutes abuse. This uncertainty was the unfreezing (Kotter 1996) that created the catalyst for change in this OD project. However, the negative consequences for the organisations reputation as a care provider can have a lasting impact as is evidenced in the media coverage. The emotional shock attached to this reactive process is best avoided and replaced with a positive pro-active environment in residential care facilities.

The No Secrets safeguarding policy in the UK recommends moving towards this pro-active approach and making an active contribution particularly to the grey areas of practice of which there are many (Department of Health 2008). Focusing on a particular event when elder abuse is detected may be counterproductive as it narrows the focus to an individual incident or the organisation rather than a broader systems failure (Mysyuk et al. 2013). This OD project demonstrates that the emphasis on the development of knowledge in caregivers is crucial to the protection
of VOA’s. While systems of screening all older adults for elder abuse is considered (Bond & Butler 2013), the literature is unanimous in identifying that the only effective means of dealing with the scale of the problems in residential care are focusing on the caregivers knowledge.

Lessons learned from this experience are that residential services need to harness the protection of VOA’s in each care centre by taking direct responsibility for the evaluation of staff training requirements. Depending on the two-year HSE mandatory training provided to all employees is not enough if systems of evaluation are not in place. Furthermore, the impact of knowledge decay has to be recognised. Having systems in place to prevent such corrosion is critical to the success of any training programme. The revised national standards for older adults in residential care settings are due to be published by HIQA on the 1st July 2016 (Appendix Twenty Three). These might offer providers greater support in the evaluation process. From a HSE perspective, the recent publication of the Safeguarding Newsletter (Appendix Twenty Four) provides enhances awareness for all employees.

The implementation of the LNP combined with the use of the KAMA tool has proven successful with a 41% increase in staff knowledge on the protection of VOA’s. This increase in staff knowledge is expected to support best practice on the prevention strategy. However, the longer the care giving experience without appropriate systems in place, then the greater the risk of abuse as inappropriate cultures evolve (Caciula et al. 2010). Establishing a LNP will change such behaviour by creating lasting systems of change that can have real long term staying power in influencing how multiple systems work toward the common goal of protecting VOA’s.
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Appendix One – Reflection one – Finding a way forward.

Description

Following the revelations on the organisation's HIQA report, staff and management in the hospital were shocked. An organisation that had invested so much time in the training and development of staff now felt very vulnerable indeed. This anxiety was heightened by local and national media coverage (Appendix eighteen). The reputation of the hospital and the service it delivered was at stake. The ripple effect throughout the organisation was one of sadness, fear and anger as the findings threatened the future registration of the hospital. I found myself in a surreal environment where staff did not know which way to turn. They needed leadership to re-establish the good reputation they once had. Having a new Director at that time was difficult for them, but they quickly established themselves as a united force. I felt I had their support from the time I started.

Feelings

Initially, I considered my role as Director of Nursing in the organisation an enormous leadership challenge in advance of the HIQA report (2015) coming to light. I had just arrived in the hospital when the report was received. It required immediate action and there was no time to consider the consequences other than ensure the safety and wellbeing of the older adults in our care. Staff felt let down at that time and needed a lot of guidance and support to help them in their duty of care.

Evaluation

In the first weeks, I was guided by the General Manager and the support I received from the Assistant Directors and Practice and Development facilitators. I quickly had
to develop my own reputation within the hospital to establish a sense urgency about what needed to happen to create improvements and to prevent this situation from arising again. I listened to my team and worked with them amalgamating a transformational and transactional leadership design as required. This involved meeting with HIQA and sending frequent update reports to them on the progress we were generating at base. The pressure at the time was difficult; supporting the organisation at one level and creating change to satisfy HIQA requirements at another level.

**Analysis**

The value of listening became a very important part of my communication strategy. The staff within had all the information they needed, however, this had to be coordinated by more effective means. As an extern to the organisation, I did not carry the emotional trauma that the HIQA report and the media coverage attracted. I was therefore able to establish myself effectively without the emotional attachment. This perhaps had the advantage of being efficient and functional at the time.

**Conclusion**

Finding a way forward following the HIQA findings involved establishing the facts and dealing with the consequences. Each day something new unfolded and to predict what might happen the next day became impossible. Reflection in action became an important skill. As leader of the organisation, I found myself questioning everything until I found the answers to my questions. It took some time for me to create the picture frame that I needed to move forward. Much of this involved developing my leadership style and creating confidence among staff. This was a steep learning
curve for me but as I created followers and developed leaders within, the sense of success gathered pace.

**Action Plan**

Having more time to support staff would have been great, however, it was a luxury I could ill afford at the time. HIQA feedback and action plans were time lined and urgent. Therefore strategically planning long and short term improvements with the team became a necessity. If any situation like this arose again, I now have the experience and the foundations developed to generate a successful outcome.
Hiqa urges action on care abuse allegations

Nursing home's reaction to claim 'not adequately investigated'

Noel Baker

Health watchdog Hiqa has raised concerns over how allegations of abuse at a nursing home were managed.

In an inspection report on the HSE-run St Finbarr's Hospital, the Health Information and Quality Authority (Hiqa) said it was not satisfied that an allegation of potential abuse had been adequately investigated prior to its being brought to their attention by a relative.

The hospital, located in Cork City, was home to 99 residents at the time of the two-day inspection last May. The report stressed numerous areas of good practice, said the centre was adequately resourced, and stated that the overall feedback from residents and family members interviewed was "complimentary of the care provided."

However, it said: "Significant improvements were required, most notably in safeguarding practices and in the design and layout of the premises."

More pressingly, the report also raised issues over bruising sustained by a resident and how the matter had been dealt with.

"The record of one resident identified that the resident presented with bruising of unidentified origin, however, records were not available to indicate that this was appropriately investigated prior to a complaint from a relative," said the report.

A notification of an allegation of abuse had been submitted to the authority as required by the regulations prior to this inspection. The allegation related to unexplained bruising on a resident.

A subsequent investigation concluded that the bruising may have been as a result of staff members assisting the resident to the ground to protect the resident from injury due to a near fall event.

"Even though staff members spoken with by inspectors were knowledgeable of what to do in the event of suspicions or allegations of abuse, based on a review of the resident's records, inspectors were not satisfied that staff demonstrated adequate awareness or responded appropriately to possible signs of abuse by not investigating unexplained bruising prior to it being brought to their attention by a relative," said the report.

"Based on a review by inspectors of the report of the investigation into the allegation, inspectors were not satisfied that the investigation was sufficiently wide-ranging to incorporate all incidents of unexplained bruising."

The report said another allegation of abuse was made to inspectors during the visit, relating to how a staff member interacted with a resident. Hiqa asked that an investigation be conducted.

In its response, the hospital's management said all staff have received training in elder abuse and that training is ongoing.

As for the primary allegation, it said: "A review of the resident's medical and nursing notes took place to identify the cause of bruising. A full medical review was completed and all staff members were interviewed. The review identified that the resident was a high risk for falls and it was determined that the bruising may have been as a result of staff members assisting the resident to the ground to protect the resident from injury due to a near fall event."

It added that the hospital has secured the placement of an independent advocate.
Centre for elderly is criticised in report

COLIN GLEESON

A large HSE-run centre for highly dependent older people in Co Louth does not have enough toilets to cater for the number of residents it accommodates, according to a report.

St Finsbar's Hospital was the subject of an announced inspection by the Health Information and Quality Authority (Hiqa) last May. While its 80 residents were found to receive a good standard of nursing and medical care, significant improvements were required.

The inspector found that in three of the centre's five units there was an "insufficient number of lavatories for the number of residents living in the centre" with only two toilets provided in each unit.

Those three units were also found to be "unsuitable" to meet residents' needs.

"This was mainly due to the limited space provided in the areas surrounding the beds," said the report. "Residents' privacy and dignity was compromised due to the close proximity of many of the beds. There was inadequate private accommodation for residents to ensure that residents' privacy and dignity was not on a daily basis.

Challenges

"In these bedrooms, inspectors observed that residents were not able to undertake personal activities in private or meet with relatives in private.

In addition, there were numerous challenges posed by the structure and layout of the physical environment." (Inspectors also criticised the facility for its failure to appropriately investigate the "unexplained bruising" of a resident until a relative made a complaint.

"A subsequent investigation concluded that the bruising may have been as a result of staff members assisting the resident to the ground to protect the resident from injury due to a near fall event," said the inspection report.

The inspectors were also "not satisfied" staff demonstrated adequate awareness or responded appropriately to possible signs of abuse "by not investigating the unexplained bruising prior to it being brought to their attention by a relative.

The report also found there was "inadequate storage space" for residents' personal property and possessions. Each resident had been provided with a lockable metal box for storing valuables.
Appendix Three – KAMA Tool

Knowledge and Management of Abuse (KAMA) *(Richardson, B., Kitchen, G., Livingston, G 2003)*

KAMA instrument version A

1a. You have returned from annual leave and find that Mrs Donoghue, an 83-year-old lady known to have memory problems, is not doing so well. She has had a urinary tract infection and has become more confused. She now requires practical assistance to get washed and to get out of her chair. As you are helping her, you discover some bruising on her arms. What would you do?

2a. You are doing agency/locum work in a long-stay setting. Miss Lawrie, an 85-year-old wheelchair-bound lady with a diagnosis of dementia asks repeatedly for a drink over a period of several hours. After some time she is told that drinks are only available at mealtimes and other prearranged times. What would you do?

3a. Mr Ferguson, a 67-year-old man whom you know has a paranoid illness, approaches you and tells you that the previous night a member of staff had been rude when they were giving out medication. He heard him shouting at an older lady that he would force her to have extra medication if she did not do as she was told. What would you do?

4a. You know that a senior member of your team is stressed by hard work and is being kept awake by small children at night. You observe him hit back when Miss Hall, an aggressive 88-year-old, hits out. What would you do?

5a. You overhear in the staff canteen a colleague explaining that he cannot stay long on his lunch break because their ward is so short staffed today. He mentions that their ward has therefore had to tie down Mr House, a 79-year-old man who has been going around hitting other residents. What would you do?

6a. Mr Flannagan is a 77-year-old recently widowed man who has been transferred from his home to a residential home. Initially he settled well, although he does not always remember that his wife died. Over the past 3 months he has been growing more irritable and has been verbally abusive towards other residents and staff. He is frequently tearful in the mornings and has been spending more time on his own. His General Practitioner diagnosed depression and the treatment included taking antidepressants, but the resident will not take them. It is suggested by the manager that his tablets are put in his morning porridge. What would you do?

7a. You know of Mr Collins, a 75-year-old with dementia in a long-stay unit, who repeatedly tries to stand up but regularly falls down. He has injured himself in the past, but won’t stop. What would you do?
Scoring sheet for KAMA version A: total score=56

1a. Speak to the patient. Ask staff or any other witnesses who may know what happened. Check written records. Produce a written report. Fill in an incident form. Inform senior member of staff. Look at care plan. Inform relatives when applicable. If senior staff are not doing anything about it, find somebody else to speak to. Inform RMO. Arrange a physical examination. Inform care manager. Update the care plan regarding handling issues. **Total score=12.**

2a. Answer yourself. Speak to the person responsible for Mrs Lawrie and ask them to answer her. Speak to the person in charge. Ascertain if this is a repeated problem e.g. from care plan. Ascertain from senior member of staff if the care plan is being followed. Make sure RMO is aware what has happened. If nothing happens go higher. **Total score=7.**

3a. Talk to the patient. Record what is said. Speak to a senior colleague. Staff to interview the accused. Record this interview in writing. Speak to witnesses. Record this in writing. If allegations sustained, expect a suspension. Report to key worker or care manager if in the community. Know if it is followed up. **Total=10.**


5a. Find out if it is true. Speak to staff. Speak to the patient. Inform the RMO. Inform superior. Inform relatives. Make sure that something is being done about it, e.g. get more staff. Document what has happened. **Total=8.**

6a. Talk to the patient. Ensure RMO is informed. Document. See if somebody else can persuade the patient to take the medication e.g. relatives. Make sure the superior knows how it is being done. Refuse to do it yourself, unless a multidisciplinary team and relatives have agreed. **Total=6.**

7a. Inform the RMO. Look at the care plan, find out if it is being carried out and that safety is addressed in the care plan. Inform the superior. Ask why – talk to the patient. Discuss with relatives if appropriate. Try to make the patient safe. Fill in an incident form for each fall. **Total=7.**
KAMA instrument version B

1b. You hear that Miss Turner, a 66 year old who is manic, saying she saw one of the night staff walking behind another patient and thrusting his pelvis in a sexually suggestive manner. What would you do?

2b. You are doing agency/locum work in a long-stay setting. You hear that Mrs Rose, an 85-year-old lady (who is not one of your patients/clients) shout out repeatedly ‘nurse, nurse’. No one comes for several hours. What would you do?

3b. Mr Daly an 88-year-old man has been recently transferred to your area from a residential home in another county, so as to be near his daughter. You notice a large cut on his forearms. What would you do?

4b. Mrs West, a 90-year-old lady who has been previously continent, has recently had several ‘accidents’ a day and for the past few days her stool has also been loose. She calls out to one of the staff who readily goes to her aid but she hits her. You observe the staff member slap her. What would you do?

5b. You are visiting a unit and are surprised that for the first time you have to wait for the door to be unlocked. You are told that this is because Mr Stone, an 85-year-old man, has been trying to get out. What would you do?

6b. Mrs Gregory, a 68-year-old lady in your care is known to be very anxious, her sleep is poor and she frequently wanders around the unit at night. The staff worry that she may fall. She is prescribed medication to settle her at night and when she takes it, she does have a very restful night and feels much better during the day. In the past she has been refusing to take her tablets at night, but you hear that this has recently improved. You are told that this is because it is added to her bedtime drink. What would you do?

7b. You hear of Mrs Finch, a physically aggressive 82 year old who has been left by herself for 10 hours over the last day in her room, because of short staffing, in order to ensure the safety of other people. What would you do?
**Scoring sheet for KAMA version B: total score=62**

1b. Talk to the patient. Record what is being said. Speak to a senior colleague. Senior colleague or the subject to speak to the accused member of staff. Record this. Speak to witness. Record this. If there is substance to the allegation, expect suspension, know how it is investigated. Report to key worker or care manager. See if allegations like this were made in the past. **Total=10.**

2b. Answer yourself. Speak to the person responsible for Mrs Rose and ask them to answer her. Speak to the person in charge. Ascertain if this is a repeated problem from the care plan. Make sure that the RMO is aware of what happened. Record this. **Total=7.**

3b. Speak to the patient. Speak to other staff and any other witnesses who may know what happened. Produce a written report in the notes. Fill in an incident form. Inform appropriate member of staff. Inform relatives if applicable. If it is thought to be abuse, speak to senior member of staff. If the senior members of staff are not doing anything about it, find somebody else to speak to. Arrange a physical examination by a doctor and document this. Tell RMO. Inform keyworker or care manager. Make sure the patient is safe. Talk to the previous residential home. **Total=13.**

4b. Document what happened. Inform superior. Talk to the member of staff if you are the superior. Fill in an incident form. Make sure that the senior is taking action. If not, how would you get around it? Make sure that the patient is OK. Talk to the patient. Inform relatives if applicable. **Total=9.**

5b. Inform RMO. Look at the care plan, find out if it is being carried out and that safety is addressed in the care plan. Inform the superior, are they allowed to lock the unit? Ask why Mr Stone wants to leave. Talk to the patient. Discuss with other staff. Discuss with relatives about the unit being locked. Are there alternatives to locking the unit? Document what you have witnessed. **Total=8.**

6b. Talk to the patient. Ensure that the RMO is informed. See if somebody else can persuade the patient to take the medication e.g. relatives. Make sure that superior knows how it is done. Refuse to do it yourself or stop others from doing it, unless multidisciplinary team and relatives agree. Document this. **Total=6.**

7b. Find out if it is true. Speak to staff. Speak to the patient. Speak to the RMO. Inform superior. Inform relatives. Make sure that something is being done about it, e.g. get more staff. Make sure that the patient is OK. Document this. **Total=9.**
Appendix Four - Stakeholder analysis.
Appendix Five - PESTLE acronym (Aguilar, 1967).

| Political                                                                 | The National standards on the Protection of Vulnerable Older Adults was published in December 2014 replaced all other PPG’s.  
|                                                                         | Full review of training required to support implementation of National standards. |
| Environmental                                                           | Legislation requires all staff to be trained in elder abuse throughout the organisational campus.  
|                                                                         | 8 Units spread individually over one large site.  
|                                                                         | Difficult to centrally manage elder abuse training.  
|                                                                         | LNP proposed to decentralise training into individual units. |
| Social                                                                  | All older adults to be protected and safeguarded from abuse regardless of capacity as per HIQA regulations.  
|                                                                         | Basic human right to feel safe and secure in their environment.  
|                                                                         | All staff obliged to deliver best practice in the protection of vulnerable older adults (HSE, 2014). |
| Technology                                                              | Media and technology have influenced the National standards as the general public have access to media and HIQA reports on services where the HSE systems failed to protect vulnerable older adults. This has greatly influenced the need to implement enhanced protective measures such as the LNP. |
| Legal                                                                   | The Health Act (2007 & 2013) and the subsequent development of the HIQA standards (2009 & 2013) supports the legal obligation of residential centres to protect the rights of vulnerable older adults at all times.  
|                                                                         | All staff have a legal obligation to report any allegations of abuse in accordance with such legislation and the National Policy on Safeguarding (HSE, 2014). |
| Economic                                                                | Reputational damage as a consequence of unreported abuse can have a catastrophic impact on the ability of a residential care setting to operate as it is in breach of the regulation standards. All staff need to be fully aware of their responsibilities in reporting incidents of suspected abuse. |
Appendix Six - SWOT Analysis.

**Strengths**

- Consistent support to practice development.
- Consistent monitoring and supervision of staff. Attitudes, behaviour and awareness at ward level.
- Monitoring trends can prevent the development of an organisational culture where inappropriate basic assumptions, if unresolved could become the norm (Schein, 1992).

**Weaknesses**

- LNP a new development within the organisation therefore stakeholder engagement (Appendix 1) may be challenging.
- No guarantee that this will impact positively of staff awareness and practice development.
- Dependent on selecting LNP’s that demonstrate commitment and enthusiasm for training to be an LNP in the first instance.
- Dependent on LNP’s being efficient in the transfer of knowledge and experience to staff at ward level therefore appropriate training and monitoring required.

**Opportunities**

- Creates a leadership opportunity for the LNP to become a Train the Trainer on Elder Abuse.
- Enhancing the knowledge of staff is expected to enhance the safety and quality in service delivery (HSE, 2014).

**Threats**

- Staff not willing to engage in the programme both at LNP level and at staff level.
- Poor stakeholder engagement.
Appendix Seven - Force Field Analysis

**Forces for Change**

2. HIQA Standards.
3. Further support for staff needed.
4. Evaluate existing knowledge base.
5. Recent HIQA report identified deficiencies in existing system.

**Plan: Implement a Link Nurse Practitioner (LNP) in each unit.**

**Total: 22**

**Forces Against Change**

1. New initiative – not yet proven.
2. Risk of staff disengagement.
3. Resistance to development of LNP.
4. Dedicating time to training and development.

**Total: 12**
Appendix Eight - Reflection three – Meeting resistance.

Description

Once the LNP training and guidance was complete all the LNP’s were released to their respective wards to initiate staff training in early December 2015. The LNP’s were enthusiastic and positive in their approach. All were instructed to capture all staff in their units for a minimum of one training session up to the end of January 2016. The LNP’s wasted no time and gathered small groups of staff per unit to initiate staff development on the protection of vulnerable older adults. Within two weeks of commencement one LNP reported to the P&D officer that some support staff on the unit refused to participate in training until they spoke to their union representative. The union representative was on leave until February 2016 which had the potential to jeopardise the time frame agreed. The P&D officers and I decided to call a meeting with the local ‘shop stewards’ to clarify what was being said about the project. The Shop Stewards explained that a minority group of non-nursing staff had raised concern about completing the KAMA tool. They were concerned that if they answered questions in correctly that it would be traced back to them and in some way it could be used as evidence against them.

It was explained to the shop stewards that this concern was genuine and we were happy to discuss the issue further with staff. However, unions had already given the project their approval. It is understandable that the issue be raised by staff now when they are in the process of documenting answers to the KAMA tool questionnaire. It was explained that this is a training and development issue and not a union issue. It was acknowledged that further
information was required for staff to understand the process and engage fully with the programme. This could be organised through a process of consultation meetings which I was happy to lead out until staff felt fully supported. This was agreed with the shop stewards. A consultation meeting was held with me, P&D, the shop stewards and support staff. Following an honest and trustworthy discussion all staff were in general agreement that the project would proceed. Any further issues were to be fed back to management. I valued this opportunity to engage with staff. P&D identified it as resistance initially and taking the right approach by valuing the staff concerns and listening to them through active engagement won the support of the staff involved to allow the OD to proceed within the planned timescale.

**Feelings**

My initial reaction was one of fear when I got the report from P&D. Once I established the facts of the matter with my initial meeting with the shop stewards I relaxed a little as I understood this resistance to be one of concern which I felt confident could be managed locally without further union involvement. When the issues were discussed with the staff at the consultation process I very much valued the staff concerns. I also felt a great sense of achievement that such concerns had been raised as it proved to me as leader that staff were taking the content of the organisational change very seriously. They had thought deeply about it and they were willing to air their views without the fear of trepidation. This is what really mattered to me – at all times they were encouraged to be open and honest with their views. This made the project authentic and gave staff members a sense of ownership as it progressed.
Evaluation

What was good about this experience was it gave me greater insight into what staff were really thinking. Following the consultation with staff the relationship between management and staff seemed to strengthen as a level of trust and respect formulated between both sides.

The initial fear of resistance was quickly turned into something positive which had real meaning to both management and staff.

Analysis

On reflection, I think a lot of time had been spent identifying and developing the role of the LNP. Perhaps staff on the ground felt excluded from that or at the very least not communicated with enough. Then when the LNP was implemented on the wards the level of resistance experienced could be the result of lack of engagement as the support staff on the ground did not understand fully what was expected of them when completing the KAMA tool.

Conclusion

When the project was being identified through stakeholder engagement the unions were consulted. This occurred in late September. It was early December when the LNP’s were set up in each unit. In hindsight another local meeting with union representatives at that point may have prevented the resistance experienced.

Also it was obvious from the views of staff at the consultation meeting that further engagement with staff was necessary for them to understand the entire process. It was assumed in the Implementation stage that the LNP
would provide that support to staff. But clearly staff expected more support at the initiation stage and further consultations at that time may have prevented the anxiety that staff experienced.

**Action Plan**

As identified above, I would engage further with these key stakeholders to prevent any such reoccurrences.
Appendix Nine - INMO Directive

Date 27th January 2016
To: PHN Reps, Community RGN Reps, Care of the Elderly Reps and RNID Representatives (Social Care Services)
CC: INMO Executive Council Members, Officers of the PHN Section, Officers of the Community RGN Section, Officers of the Care of the Elderly Section and Officers of the RNID Section
From: Phil Ni Sheaghdha, Director of Industrial Relations, INMO
Re: Safeguarding Vulnerable Persons at Risk of Abuse

Dear Colleagues,

The INMO were recently advised by members that the HSE Social Care Division had introduced a national policy and procedures titled *Safeguarding Vulnerable Persons at Risk of Abuse*. This policy is dated December 2014.

INMO members objected to this policy based on the lack of consultation with them and also the additional responsibilities it appears would be placed on INMO members regarding roles currently undertaken by other grades within the health services.

At the National Joint Council meeting held yesterday, Tuesday 26th of January 2016, the INMO raised this matter as an issue requiring an urgent meeting with the HSE. We have requested that no implementation or training be requested of any INMO member until full consultation has taken place with the INMO and other unions at national level.

You should advise your manager of these facts if requested to partake in training or if other changes to your current role are suggested.

We will advise members of the date of this meeting when arranged, and would welcome nominations from INMO representatives in community care of the elderly and ID services to attend with officials.

Thank you for your attention to this notice,

Is Mise

Phil Ni Sheaghdha,
Director of Industrial Relations

Appendix Eleven - Reflection four – Winning the support of key stakeholders.

Description

Winning the support of key stakeholders is critical to the success of any change project. Being new to the organisation, this was even more important to me as leader, as staff needed time to get to know me and build up an acceptance of trust. Winning the support of two key stakeholders (Practice and Development Officers) P&D, would motivate others to follow as staff felt secure in the knowledge that they could trust P&D to support best practice. However, as the LNP was an entirely new concept. The storming sessions helped tease out the issues such as liability, adequate knowledge and doing what was right for the patient. The legal aspect of the implementation of the LNP was questioned. However, as the LNP was there to support the existing training and not replace it, both P&D officers considered it a worthy project to proceed with. Furthermore HIQA were fully supportive of any new initiative to protect the safety and well-being of residents.

Feelings

Even though the P&D officers was very supportive of the change they also questioned it deeply. I did not feel threatened by the resistance as I understood it was out of genuine concern about doing what was legal and above board for the resident’s and the staff. Once everything was explained clearly, the anxiety the P&D officer experienced faded and the support received going forward was fantastic. Because both P&D officers now believed in the project they quickly won over the support of staff that the
Director as leader would have found very challenging. Ensuring the author as leader had the support of P&D went a long way towards securing the support of all other participants.

**Evaluation**

Giving the P&D officers the time and support they needed to proceed with the project was very important to them as facilitators and to me as leader. I needed to be assured that they fully supported the project in advance of trying to convince other staff that it was worthwhile. Once P&D were on board everything positive in the initiation stage stemmed from there. The brainstorming sessions were very successful and generated a lot of good ideas. It was also a great opportunity for P&D to tease out the issues and let everyone have a say. Once the words were categorised into topics it was possible to create the fishbone which gave all staff a very clear vision on how the programme could proceed. Throughout this process staff were allowed full participation and very much in control of the outcome i.e. to implement the LNP with the rationale they themselves had created. P&D were the key facilitators that made this happen. The author as leader simply guided the process.

**Analysis**

P&D questioning the project forced the author as leader to think more deeply about it and refer back to the literature as it was the literature that very much informed the author of the need to proceed. However, this process needed to make sense to the key stakeholders. As P&D understood the hospital staff and culture so well they were the ones that would truly win over the support of
the other key stakeholders. Therefore the investment of the author’s time now
would pay dividends at a later date which of course it did.

Conclusion

I could have proceeded quickly with the support of the one P&D officer but
this may have divided the one invaluable resource I had. Having the support
of two P&D officers created strength in numbers and their enthusiasm for the
project generated a momentum that would have been very difficult to grasp
otherwise.

Action Plan

If something similar arose again I would give P&D the dedicated time they
deserved. Their level of questioning heightened my awareness. The anxiety
would then have been transformed into time dedicated to exploring the real
issues and concerns.
Appendix Twelve - Pathway for the initiation of the Link Nurse Practitioner (LNP).

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>26/08/2015</td>
<td>Received HIQA report alerting HSE of allegation of abuse in organisation.</td>
<td>Internal HSE investigation launched with preliminary screening and follow up report sent to HIQA.</td>
</tr>
<tr>
<td>01/09/2015</td>
<td>Series of meetings with hospital Management and staff.</td>
<td>To inform staff of HIQA report and every staff members responsibility in safeguarding the protection of vulnerable older adults (VOA).</td>
</tr>
<tr>
<td>02/09 – 30/09/2015</td>
<td>Full stakeholder engagement through brainstorming sessions x 3 with DON and P&amp;D</td>
<td>To identify a pathway forward to enhance the protection of VOA. Staff were already being updated on the mandatory HSE training programme on elder abuse.</td>
</tr>
<tr>
<td>21/09/2015</td>
<td>Agreed with senior management to sign off on the implementation of a LNP specifically trained on the protection on VOA for each of the 8 units in the organisation.</td>
<td>Expressions of interest sent to each unit requesting nominations from staff Nurse grade upwards.</td>
</tr>
<tr>
<td>28/09 – 05/10/2015</td>
<td>Stakeholder analysis identified with P&amp;D. Agreed to inform union representatives.</td>
<td>Received buy in as a training and development project. The LNP expected to enhance the training already delivered on site.</td>
</tr>
<tr>
<td>31/10/2015</td>
<td>Nominations received from each unit and the LNP’s received their training and certificates on the HSE Train the Trainer programme.</td>
<td>Pathway created for the introduction of the LNP into each unit.</td>
</tr>
<tr>
<td>01/11 – 30/11/2015</td>
<td>4 further meetings held with the new LNP’s, P&amp;D and senior management to give training on the role of the LNP and capture the use of the KAMA tool</td>
<td>By the 1st December 2015 the LNP’s were implemented into each unit.</td>
</tr>
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Appendix Thirteen - Local PPG on the Safeguarding of Vulnerable Persons at risk of abuse (HSE, 2014).

**SFH Cork, HSE South, Residential care units and rehabilitation units.**

<table>
<thead>
<tr>
<th>Title</th>
<th>Local Policy, Procedure and Guideline - The Safeguarding of Vulnerable Persons at Risk of Abuse in St. Finbarr’s Hospital Cork, HSE South, Residential Care units and Rehabilitation Units.</th>
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<tbody>
<tr>
<td>Number</td>
<td>P/PR-ESD-016</td>
</tr>
<tr>
<td>Approved by</td>
<td>ESQIT</td>
</tr>
<tr>
<td>Approval date</td>
<td>September 2015</td>
</tr>
<tr>
<td>Issue date</td>
<td>October 2015</td>
</tr>
<tr>
<td>Reviewed</td>
<td>October 2015</td>
</tr>
<tr>
<td>Review date</td>
<td>October 2017</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Xxxxx, Xxxxx (attribution xxx, xxx, xxx)</td>
</tr>
</tbody>
</table>

**Related Policies**

- Protected Disclosure
- Complaints Policy Your Service Your say
- Privacy and Dignity Policy
- Restraint/enabler policy
- Trust in Care policy
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<td>4.3 Disclosure</td>
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<td>4.4 Concern/suspicion</td>
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<td>5 Roles and Responsibilities</td>
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<td>6 Procedure</td>
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<tr>
<td>6.1 Disclosure to a member of staff during day or night time hours</td>
<td>6</td>
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<td>6.2 Where a concern is expressed by a family member, relative or a neighbour</td>
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<tr>
<td>6.3 When a member of staff has a concern regarding a patient during day or</td>
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<td>6.4 When concern related to a staff members treatment of a patient</td>
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<td>6.5 When concern relates to a staff member's treatment of a patients</td>
<td>7</td>
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<td>6.5 Social work procedure for assessing allegations of elder abuse/abuse</td>
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Background

In 1999 a working group was established by the Department of Health And Children to examine the issue of Elder Abuse in Ireland. In 2002 the group reported its findings in a publication entitled ‘Protecting our Future’ – “The Working Group Report on Elder Abuse”. One of the recommendations was that “a clear policy on Elder Abuse is formulated and implemented at all levels of governance within the health, social and protection services in Ireland”. (Appendix 1)

In 2007 the nation quality standards for residential care setting for older people were developed by the Health Information and Quality authority (HIQA); and these became law in 2009. In 2008 the report of the commission on patient safety and quality assurance state that the overall objective of the commission is to develop clear and practical recommendation to ensure that quality and safety of care for patients is paramount within the healthcare setting.

In December 2014: National Policy and Procedures “Safeguarding Vulnerable Persons at Risk of Abuse” incorporating Services for Elder Abuse and for Persons with a Disability was launched from the Social Care Division of the HSE. St. Finbarr’s Hospital adopts the principles of this policy.

1. Policy Statement

HIQA residential standards 2008 (legislation SI 236 (2009)) state that each resident is protected from all forms of abuse (National Quality Standards for Residential Care setting for older people in Ireland. Standard 8 Protection).

HIQA define elder abuse 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 wellbeing, 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 (HIQA 2013, p 107).*

This policy outlines procedures for the prevention of abuse responding to suspicions, allegations, or evidence of abuse, or neglect reporting concerns and/or allegations of abuse to the Health Service Executive and Chief Inspector. (HIQA standard 8.1)

2. Statement of Purpose

This purpose of this policy is that all patients male and female who disclose concerns about their welfare or where staff or family have similar concerns are listened to and responded to according to the procedures outlined below
3. Scope
This policy document applies to all staff and volunteers who work in St. Finbarr’s Hospital. This includes the residential wards, the rehabilitation wards, the Stroke Unit and the Assessment and Treatment Centre. It applies to all patients male and female who attend the hospital.

4. Definitions

4.1 Elder abuse
Elder Abuse as per HIQA definition may take a variety of forms.

The HIQA definition excludes self-neglect which is the inability or unwillingness to provide for oneself (HSE, 2014). However the HSE acknowledges that people may come in to contact with individuals living in conditions of extreme self neglect. To address this issue the HSE have developed a specific policy to manage such situations and –see Section 3, Page 44 of the National Policy (HSE, 2014).

The HIQA definition focuses on acts of abuse by individuals, however, abuse can also arise from inappropriate or inadequate programmes of care.

Forms of abuse

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

Psychological abuse, including 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.

Sexual abuse, including rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent.

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

Neglect and acts of omission, including 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, including racism, sexism that is 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

Self - neglect
Deliberate physical neglect of self by an individual (see Section 3, National Policy, HSE 2014).

Disclosure
Where a patient, family member, relative or member of the community makes it known to a staff member that the patient may be subjected to Elder Abuse.

4.4 Concern/suspicion
Where a member of staff has a belief that a patient may be a victim of Elder Abuse without definite proof. This belief may be formed for example if a patient presents with unexplained injuries or with injuries which are inconsistent with the history given. Information provided by family or relatives may also give rise to concern.

Roles and Responsibilities
It is the responsibility of the Director of Nursing to ensure that all CNM2’s have received a copy of this policy in hard copy and by email.

It is the responsibility of the Domestic Supervisor(s) and ADON (Support Services) to ensure that all Attendants are notified of this policy.

It is the responsibility of each CNM2 to ensure that this policy is available in each ward and unit of care to every member of staff & that procedural elements are adhered to.

It is the responsibility of each CNM2 to ensure that each member of nursing staff, Care Assistant and Attendant staff have opportunity to read this policy and sign the required declaration.

It is the responsibility of the Director of Nursing to ensure that this policy is evaluated every 2 years or more frequently if required.

Procedure

Disclosure to a member of staff during day or night time hours

1. Acknowledge and assure that concern will be taken seriously and followed up
2. Communicate information verbally with Clinical Nurse Manager (CNM) or Deputy in Charge.
3. CNM/Deputy in Charge will ensure safety of patient in a private environment and advise them of this policy.
4. Best practice dictates that the member of staff (clinical or non-clinical) who receives disclosure must make a written note of what is said in the patient’s own words. This note should indicate where the disclosure took place and who was present. This note must be signed and dated by the staff member and made available to the Director of Nursing / Deputy on duty at the time.
5. If disclosure is raised at night, night superintendent to ensure transfer of information to day ADON / CNM3 /Director of Nursing in charge (following general report)
6. ADON / CNM3 will notify the Consultant or Registrar on duty and the Director of Nursing.
7. Verbal (followed by written) referral to Social Work Department – Cork South by Geriatrician / Director of Nursing will occur immediately the facts are known of the alleged concerns.
8. The Director of Nursing / Deputy will in turn notify the General Manager of the allegations verbally and in writing. The Safeguarding and Protection Team will be notified within three working days by the Director of Nursing/General Manager
9. Informal discussion to take place between Elderly Care Social Worker (ECSW), Nursing and Medical team as to how to proceed.
10. Elderly Care Social Worker to discuss consent issues with patient
11. If patient gives consent, Elderly Care Social Worker to complete assessment and final decision of multidisciplinary team given once assessments are completed
12. If patient refuses consent or does not have the capacity to consent, a review discussion on how to proceed with the nursing and medical team should ensue and the General Manager/ Safeguarding and Protection Team will be involved in this decision.
13. Notification to the Cork South Safeguarding Team (if not already involved) will be made at the conclusion of the meeting / discussion in relation to the allegation.
14. Stage 1 to stage 3 of the preliminary screening process to be followed as appropriate as per HSE National policy Guidelines (Pg 27 to Pg 39) (HSE, 2014).
15. The Director of Nursing/ A/DON will complete a HIQA notification form (NF06) within 3 days of the allegation and submit to HIQA using the agreed process.

**Where a concern is expressed by a family member, relative or a neighbour during day or night time hours**

1. Acknowledge and assure that concern will be taken seriously and followed up
2. CNM/Deputy in Charge will ensure safety of patient in a private environment and advise them of this policy.
3. Best practise dictates that the member of staff (clinical or non-clinical) who receives disclosure must make a written note of what is said in the patient’s own words. This note should indicate where the disclosure took place and who was present. This note must be signed and dated by the staff member and made available to the Director of Nursing / Deputy on duty at the time.
4. If disclosure is raised at night, night superintendent to ensure transfer of information to day duty ADON / CNM3 /Director of Nursing in charge (following general report)
5. ADON / CNM3 will notify the Consultant or Registrar on duty and the Director of Nursing.
6. Verbal (followed by written) referral to Social Work Department – Cork South by Geriatrician / Director of Nursing will occur immediately the facts are known of the alleged concerns.
7. The Director of Nursing / Deputy will in turn notify the General Manager of the allegations verbally and in writing, who in turn will notify the Safeguarding and Protection Team, HSE South.
8. Informal discussion to take place between Elderly Care Social Worker (ECSW), Nursing and Medical team as to how to proceed.
9. Elderly Care Social Worker to discuss consent issues with patient
10. If patient gives consent, Elderly Care Social Worker to complete assessment and final decision of multidisciplinary team given once assessments are completed
11. If patient refuses consent or does not have the capacity to consent, a review discussion on how to proceed with the nursing and medical team should ensue and the General Manager / Integrated services Manager / LHO will be involved in this decision.
12. Notification to the Cork South Safeguarding Team (if not already involved) will be made at the conclusion of the meeting / discussion in relation to the allegation.

13. Stage 1 to stage 3 of the preliminary screening process to be followed as appropriate as per HSE National policy Guidelines (Pg 27 to Pg 39) (HSE, 2014).

14. The Director of Nursing/ A/DON will complete a HIQA notification form (NF06) within 3 days of the allegation and submit to HIQA using the agreed process.

When a member of staff has a concern regarding a patient during day or night time hours

1. Communicate verbally with CNM/Director of Nursing/night superintendent regarding concern
2. CNM/Director of Nursing/Night superintendent will clarify issue.
3. CNM/Deputy in Charge will ensure safety of patient in a private environment and advise them of this policy.
4. Best practise dictates that the member of staff (clinical or non-clinical) who receives disclosure must make a written note of what is said in the patient’s own words. This note should indicate where the disclosure took place and who was present. This note must be signed and dated by the staff member and made available to the Director of Nursing / Deputy on duty at the time.
5. If disclosure is raised at night, night superintendent to ensure transfer of information to day ADON / CNM3 /Director of Nursing in charge (following general report)
6. ADON / CNM3 will notify the Consultant or Registrar on duty and the Director of Nursing.
7. Verbal (followed by written) referral to Social Work Department – Cork South by Geriatrician / Director of Nursing will occur immediately the facts are known of the alleged concerns.
8. The Director of Nursing / Deputy will in turn notify the General Manager of the allegations verbally and in writing. The Safeguarding and Protection Team will be notified within three working days by the Director of Nursing/General Manager.
9. Informal discussion to take place between Elderly Care Social Worker (ECSW), Nursing and Medical team as to how to proceed.
10. Elderly Care Social Worker to discuss consent issues with patient
11. If patient gives consent, Elderly Care Social Worker to complete assessment and final decision of multidisciplinary team given once assessments are completed
12. If patient refuses consent or does not have the capacity to consent, a review discussion on how to proceed with the nursing and medical team should ensue and the General Manager / Integrated services Manager / LHO will be involved in this decision.
13. Notification to the Cork South Safeguarding Team (if not already involved) will be made at the conclusion of the meeting / discussion in relation to the allegation.
14. Stage 1 to stage 3 of the preliminary screening process to be followed as appropriate as per HSE National policy Guidelines (Pg 27 to Pg 39) (HSE, 2014).
15. The Director of Nursing/ A/DON will complete a HIQA notification form (NF06) within 3 days of the allegation and submit to HIQA using the agreed process.

When concern relates to a staff member’s treatment of a patient

If concern relates to a staff member’s treatment of a patient refer to “Trust in Care” Policy Document May 2005 - Procedure for Managing Allegations of Abuse against Staff Members ²

The General Manager / Safeguarding and Protection Team will also be informed in order to establish the need for an investigation following preliminary screening.
Social work procedure for assessing allegations of Elder Abuse/Abuse of Vulnerable Adult (Cork South Elder Abuse Officers / Social Workers)

1. Establish:
   (a) Exact nature of concerns
   (b) Who is raising concern
   (c) Where is it alleged to have happened
   (d) Who is the alleged perpetrator
   (e) What is nature of their contact/relationship with alleged victim
   (f) Is there any physical evidence of allegation
   (g) Are there any independent witnesses to alleged abuse

2. If the allegation is made by another professional it must be documented. If raised by a relative of friend or alleged victim, anonymity cannot be given

3. Discuss the allegation with the alleged victim where possible, establishing their view of the allegation. Advise of social and legal options where appropriate

4. Establish consistency of allegation with other relevant professionals i.e. Family members, GP, Nursing Staff, Geriatric team, other members of Multidisciplinary Team where appropriate

5. Establish the view of other significant adults/next of kin where appropriate

6. Establish view of alleged perpetrator where appropriate

7. Develop support plan

8. Development of safety plan where appropriate

9. Refer to relevant legal authorities where appropriate

10. Liase with and refer to Senior Case Workers, Protection Services for Older People, where appropriate.

Elderly Care social worker / Elder Abuse Social Workers

St. Finbarr’s Hospital does not have a designated social worker on site. This service is coordinated via the acute services in Cork University Hospital where 10.5 hours of time is allocated to St. Finbarr’s Hospital weekdays on Tuesday and Friday (excluding Bank Holidays). All allegations of Elder abuse are notified to the Elder abuse protection Officers in Cork South.

7.0 Training

1. Elder Abuse training is mandatory for all staff in SFH.
2. Elder abuse trainers will be maintained on site to allow full roll out of the Elder abuse course for all staff.

8.0 Implementation of Link Nurse Practitioner’s (LNP) in all units (Oct 2015)

Following a HIQA inspection in 2015 the effectiveness of staff training and development in relation to the safeguarding and protection of vulnerable older adults was questioned. HIQA required evidence that current systems of training were effective. It was agreed following discussion with staff that an additional safeguarding measure would be introduced into SFH to support staff development. A LNP
specifically trained on the protection of vulnerable older adults was thereby implemented into each unit in October 2015 for a period of 6 months initially. If deemed successful in supporting and developing staff following a process of evaluation in April 2016, the programme may be extended for a greater length of time under periodic review. **Full participation of staff members is required at ward level. Please consult with your ward manager to identify your LNP.**

**References:**

4. National Quality standards for
   i. Residential care settings for older people in Ireland (HIQA, 2008)
   ii. National Standards for Residential Services for Children and Adults with Disabilities (HIQA 2013).
5. National Policy and Procedures from the Social Care Division
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<th>Notification</th>
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<td>Any allegation, suspected or confirmed abuse of any resident</td>
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<tr>
<th>Date of alleged abuse:</th>
<th>Time of alleged abuse (please state AM or PM clearly)</th>
<th>Date of report of abuse</th>
<th>Time of report of abuse (please state AM or PM clearly)</th>
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**Type of abuse (please tick all that apply)**

- [ ] Physical abuse
- [ ] Sexual abuse
- [ ] Psychological abuse
- [ ] Financial/material abuse
- [ ] Neglect
- [ ] Discriminatory abuse
### Alleged abuser(s) relationship with the person (please tick all that apply)

- [ ] Staff member/professional employed at the centre
- [ ] Volunteer
- [ ] Visiting care worker or professional
- [ ] Relative
- [ ] Friend
- [ ] Unknown
- [ ] Other (please specify)

### Action taken:


### Declaration

The information I have provided in this notification form is true to the best of my knowledge and belief.

Notifications made on behalf of companies or other corporate bodies should be signed by a duly authorised person.

**Signed:**

**Name:**

(please print)

**Position:**

**Date:**  __/__/__

DAY/MONTH/YEAR
On completion of this form
Please return the completed signed form by email to notify@higa.ie

Alternatively you may post or fax it to your regional Health Information and Quality Authority office. You can find the address and fax number of your regional office by checking the table below. Please mark faxes for the attention of 'Notifications section'.

Northern Regional Office
Health Information and Quality Authority
Social Services Inspectorate
Georges Court
Georges Lane
Smithfield
Dublin 7
Fax: 01 814 7499

Central Regional Office
Health Information and Quality Authority
Social Services Inspectorate
Georges Court
Georges Lane
Smithfield
Dublin 7
Fax: 01 814 7499

Southern Regional Office
Health Information and Quality Authority
Social Services Inspectorate
Unit 1301
City Gate
Mahon
Cork
Fax: 021 240 9600

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<th>Southern Regional Office covers the following HSE local health office areas:</th>
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<td>o Carlow/Kilkenny</td>
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<td>o Donegal</td>
<td>o Dublin South City</td>
<td>o Cork North</td>
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<td>o Cork South Lee</td>
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<td>o Dublin West</td>
<td>o Cork West</td>
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<td>o Longford/Westmeath</td>
<td>o Dun Laoghaire</td>
<td>o Kerry</td>
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<td>o Kildare/West Wicklow</td>
<td>o Tipperary South</td>
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<td>o Meath</td>
<td>o Laois/Offaly</td>
<td>o Waterford</td>
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NFO6
SAFEGUARDING VULNERABLE PERSONS AT RISK OF ABUSE

NATIONAL POLICY & PROCEDURES PRELIMINARY SCREENING FORM (PSF1)

Please indicate as appropriate: Community setting: □ Service setting: □

1. Details of Vulnerable person:

Name:
Home Address:
Current Phone No:
Date of Birth: / / Male □ Female □
Location of vulnerable person if not above address

Service Organisation (if applicable):
Service Type:
Residential Care □ Day Care □ Home care □ Respite □ Therapy intervention □
Other □ (please specify)

Designated Officer (DO) Name:
Community Health Organisation (CHO) Area:

2. Details of concern/allegation:

a. Pen picture of vulnerable person:
b. Details of concern / allegation including time frame:

c. Was an abusive incident observed and details of any witnesses:

d. Relevant contextual information:

e. Have any signs or indicators of abuse been observed and reported to the designated officer? Please specify?
f. Details of investigation/ assessment to date?


g. Is it deemed at this point that there is an ongoing risk? If so please specify?


h. Include any incident report or internal alert details if completed (as attachment):


i. Details of any internal risk escalation:


3. Relevant information regarding concern/allegation:

Date that concern or allegations were notified to the Designated Officer:

Who has raised this concern or allegation?

Self □ Family □ Service Provider □ Healthcare staff □ Gardaí □

Other □ *(please specify)*

Type of concern or category of suspected abuse:

Physical Abuse □ Sexual Abuse □ Psychological Abuse □ Financial / Material Abuse □

Setting / Location of concern or suspected abuse:

Own Home  □  Relatives Home  □  Residential Care  □  Day Care  □  Other (please specify)

Is this concern/allegation linked to another preliminary screening? If so please give reference

Are there any concerns re: decision making capacity?  Yes □  No □

Are you aware of any formal assessment of capacity being undertaken?  Yes □  No □

Outcome:

Is the Vulnerable person aware that this concern has been raised? Yes □  No □

What is known of the vulnerable person’s wishes in relation to the concern / allegation?

Are other agencies involved in service provision with this vulnerable person that you are aware of?  Yes □  No □

If yes, Details:

4. Details of the first point of contact:

Name:

Address:

Phone:

Nature of relationship to vulnerable person (i.e. family member/ advocate etc):
Is this person aware that this concern has been reported to the Designated Officer?

Yes ☐ No ☐ Not know ☐

If no – why not?
If yes – date
by whom?

Has an Enduring Power of Attorney been registered in relation to this Vulnerable Person?

Yes ☐ No ☐ Not know ☐

Contact details for Registered Attorney(s):

Is this Vulnerable Person a Ward of Court? Yes ☐ No ☐

Contact details for Committee of the Ward:

Has any other relevant person been informed of this preliminary screening?

Details?

5. Details of person causing concern:

Name:
Address:
Date of Birth (if know)
Gender: Male ☐ Female ☐

Relationship to Vulnerable person:

Parent ☐ Son/Daughter ☐ Partner/Spouse ☐ Other Relative ☐ Neighbour/Friend ☐ Staff
☐ Other Service User / Peer ☐ Volunteer ☐ Stranger ☐

Other ☐ (please specify)
6. Details of Person completing preliminary screening

Name: Phone:

Address:

Job Title: Are you the Designated Officer:

Email: Date

---

**Preliminary Screening Outcome Sheet (PSF2)**

Name of Vulnerable person:

a) No grounds for further investigation □
   (If necessary attach any lessons to be learned as per policy)

b) Additional information required (Immediate safety issues addressed and interim safeguarding plan developed) □

c) Reasonable grounds for concern exist (Immediate safety issues addressed and interim safeguarding plan developed) □
   Additional actions undertaken:

   d) Medical assessment Yes □ No □ N/A □
   e) Medical treatment Yes □ No □ N/A □
   f) Gardai notified Yes □ No □ N/A □

An 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.

g) Referred to TUSLA Yes □ No □ N/A □

h) Other relevant details including any immediate risks identified:

(Attach any interim safeguarding plan on appendix 1 template as required)
If the preliminary screening has taken longer than three working days to submit please give reasons:

Name of Designated Officer/ Service Manager:

Signature:

Date sent to Safeguarding and Protection Team:

---

**Preliminary Screening Review Sheet from the Safeguarding and Protection Team (PSF3)**

Name of Vulnerable person:

Unique Safeguarding ID generated:

Date Received by SPT: Date reviewed by SPT:

Name of Social Work Team Member reviewing form:

Preliminary Screening agreed by Safeguarding and Protection Team

Yes ☐ No ☐
If not in agreement with outcome at this point outline of reasons:

Commentary on areas in form needing clarity or further information:

Any other relevant feedback including any follow up actions requested:

Name:                                                   Signature:

Date review form returned to Designated Officer/ Service Manager:
Preliminary Screening Review Update Sheet from Designated Officer/Service Manager (PSF4):

(Only for completion if requested by Safeguarding and Protection Team)

Name of Vulnerable person:

Unique Safeguarding ID: Date returned to SPT:

Name of Designated Officer/Service Manager: Signature:

Reply with details on any clarifications, additional information or follow up actions requested:

Date received by SPT: Date reviewed by SPT:

Preliminary Screening agreed by Safeguarding and Protection Team

Yes □ No □

Name of SPT Team Member reviewing form:

Signature:

If not in agreement with outcome at this point give outline of reasons and planned process to address outstanding issues in preliminary screening:
Interim Safeguarding Plan. Please include follow up actions and any safety and supports measures for the Vulnerable Person:

Name of Designated Officer/ Service Manager:  

Date of Interim safeguarding plan:  

<table>
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<tr>
<th>What are you trying to achieve?</th>
<th>What specific follow up or safeguarding actions are you taking to achieve this?</th>
<th>Who is going to do this?</th>
<th>When will this be completed?</th>
<th>Review date for actions:</th>
<th>Review Status/Update</th>
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There is duty of care to report allegations or concerns regardless of whether client has given consent

Referrer should take any immediate actions necessary as per policy in relation to seeking An Garda Síochana or medical assistance

**Vulnerable Person’s Details:**

Name: _______________________________ DOB: _______________________________

Address: __________________________________________________________________________

Marital Status: __________________________

Contact Phone Number :/Mobile: ______________________________

Does anyone live with client: Yes □ No □ If yes, who: ______________________________

Medical history and any communication support needs (as understood by referrer):
__________________________________________________________________________________
__________________________________________________________________________________

Details of the person’s vulnerability (as understood by referrer):
__________________________________________________________________________________
__________________________________________________________________________________

Is client aware this referral is being made? Yes □ No □

Has client given consent? Yes □ No □

Is there another nominated person they want us to contact, if so please give details?
Name: _______________________________ Contact Details: _______________________________

Relationship to vulnerable person: __________________________

GP Contact Details:
Name: _______________________________ Telephone: _______________________________

Primary care team details i.e. social worker, PHN, etc.
__________________________________________________________________________________

Any other key services/agencies involved with client (*Please include Name and Contact*):
Details: ______________________________________________________________________________________
____________________________________________________________________________________
Details of allegation/ concern: Please tick as many as relevant:

<table>
<thead>
<tr>
<th>Physical abuse</th>
<th>Financial/material abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Financial/material abuse</td>
</tr>
<tr>
<td>Psychological/Emotional abuse</td>
<td>Neglect/acts of omission</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Discriminatory abuse</td>
</tr>
<tr>
<td>Extreme Self Neglect*</td>
<td>Institutional abuse</td>
</tr>
</tbody>
</table>

(extra sheet/report can be included if you wish)

Details of concern:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

(*If self neglect is being referred please complete and attach presence of indicators of extreme self-neglect)

Details of Person Allegedly Causing Concern (if applicable)

Name: __________________________ Relationship to vulnerable person: __________________________

Address: _______________________________________________________________________________

Is this person aware of this referral being made: Yes □ No □

Details of person making referral:

Name: __________________________ Job Title (if applicable): __________________________

Agency/Address: __________________________________________________________________________

Landline________________________ Mobile: __________________________

Signature________________________ Date: __________________________
Root cause Analysis.

Environment.
To create a culture of no tolerance to the risk of elder abuse occurring.

Resident.
To enhance current safeguarding measures on wards and ensure care is appropriate at all times.

Method.
Developmental support for staff. Brief 20 min sessions at random to facilitate all staff. Use of KAMA tool to monitor effect.

Staff.
Actively involve staff at ward level to discuss issues and concerns as they arise. Maintain vigilance for mandatory HSE reporting as per policy.

Why implement a LNP specifically trained on the protection of VOA?
## Appendix Fifteen - Mini Gantt Chart.

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Catherine White</th>
<th>Student ID:</th>
<th>14138476</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify Nursing staff in 8 units to attend the HSE Train the Trainer (TTT) on Elder Abuse</td>
<td>8 LNP's received HSE TTT 22nd Sept 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement Identified LNP on Elder Abuse to 8 units.</td>
<td></td>
<td>Team meetings for process mapping</td>
<td>Implemented 1st Nov 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop a data base of staff training needs on each unit with LNP by 01/11/15.</td>
<td></td>
<td>Nursing Admin office organise training folder for each unit</td>
<td>Implemented 1st Nov 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LNP identify baseline staff knowledge in each unit by 01/02/16 using KAMA A in advance of LNP training.</td>
<td></td>
<td>KAMA A Tool distributed to all units</td>
<td>KAMA A results collected by 1st January</td>
<td>Results KAMA A scored 1st Feb 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Staff compliance with LNP training by 01/02/16 – KAMA A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>71% compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify change in staff knowledge using KAMA B by 01/04/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>KAMA B Tool distributed to all units</td>
<td>KAMA B results collected in 2 units by 3rd April 2016</td>
<td>From 4th April compared KAMA results Staff Q – out 5th April 2016</td>
<td>First complete draft proof read by 1st May 2016</td>
<td>Make changes</td>
</tr>
<tr>
<td>Write up study – compare KAMA A &amp; KAMA B results (quantitative analysis) : Do Staff questionnaire (qualitative analysis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submit Thesis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12th May 2016</td>
</tr>
</tbody>
</table>
Appendix Sixteen – Process map

**Rational for implementation of LNP**

To support best practice in the Safeguarding and Protection of Vulnerable Older Adults (HSE, 2014) by enhancing the knowledge of staff at ward level to recognise and respond to any practices that may place older adults at risk of abuse.
Appendix Seventeen – Reflection five – Additional Support Needed.

Description

When the LNP was introduced it was considered appropriate to appoint one LNP in each ward area to administer staff training and development on the safeguarding of vulnerable older adults for the staff appointed that unit. At the time of planning and initiation having extra LNP’s to call on if required was not considered necessary as each LNP was a staff Nurse or Nurse Manager appointed to each unit.

The target was set for all staff in each unit having completed KAMA tool A and attending at least one training and development session by the end of January 2016. This was considered achievable by all in LNP’s. However, there was an unequal divide in bed capacity with some wards as low as 13 beds per unit and others as high as 38 beds which inevitably required higher staffing levels. As a result, the LNP’s in the larger units reported by the first week of January 2016 that they could not foresee meeting their target as they had staff on leave over the Christmas period and felt pressurised to get through so many sessions by the end of January.

Feelings

Once the LNP’s brought this to our attention, I felt it was short sighted of us not to have trained up at least 2 LNP’s in the larger units. At the time we only advertised for one per unit in the format of expressions of interest. As it was a new venture, in many ways we were finding our way as leaders in the hope that we could generate interest. When interest did come forward, we were relieved that we had one LNP assigned to each unit for this 6 month pilot project. In hindsight we should have
recognised that the larger units (2 in total) would need additional supports to cover all the staff training in the agreed time frame.

**Evaluation**

What was agreed following the LNP’s concern was the P&D officers would support the 2 larger units with extra sessions in January to ensure all staff were covered. On the positive, the LNP’s felt this would be great support to them. Furthermore it acknowledged to team contribution in sustaining this OD. The P&D officers therefore worked with the LNP to capture all the staff rather than taking over sessions of their own accord.

**Analysis**

This was a predictable outcome that should have been better planned for. However, the focus was on the introduction of the LNP and how this role could best support the protection of the vulnerable older adult. The demographics attached to unit size and contingency measures was something that could be assessed further when the actual role was established and considered fit for purpose.

**Conclusion**

It could have been planned out with each LNP the amount of staff each unit had to cover within the agreed timeframe. However, this would have reduced the LNP’s sense of autonomy and control as leader. Allowing the LNP to identify their own deficits supported them contemplating a strategy forward. What was evident was their willingness to continue and ensure the agreed timeframe was achieved. To
support them in their efforts it was agreed to delay the feedback from Kama tool B by three weeks to give every staff member enough time to be involved. This would delay the write up of the OD by a few weeks also but I believed this was necessary. What was most important was ensuring staff were well supported in practice and benefiting from the introduction of the LNP. This gave the LNP’s and the staff the support and respect they deserved in implementing this project.

**Action Plan**

I am satisfied that as the issue arose it was acknowledged and managed efficiently. However, more consideration of the demographics at the planning stages may have prevented it from occurring. Sometimes you cannot plan for everything in theory until you put it into practice. Had I been more familiar with the organisation at the beginning, I believe this could have been easily forecast and planned for. When it was easily resolved it gave further reassurance to all stakeholders that all members of the team were fully committed to supporting each other. This is publicity you cannot canvas for, it has to be experienced by both leader and follower.
Appendix Eighteen – Staff Survey.

Safeguarding the Protection of Vulnerable Adults (HSE, 2014). Feedback on the implementation of a Link Nurse Practitioner (LNP) in St. Finbarr’s Hospital.

Participants please answer questions No. 1 to No. 4.

If you are a LNP, please answer questions No. 1 to No. 6.

Thank you in advance for your feedback. It will be used to inform best practice.

1. How did the implementation of the LNP support you in your role on the protection of Vulnerable Older Adults (VOA’s)?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. What worked well for you?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
3. How could the LNP implementation be improved?

4. How did the LNP influence the way you do your work?

5. If you are a LNP, please confirm your experience to date?
6. As a LNP is there anything you would suggest could be done differently? Please give rationale for your answer.
# Appendix Nineteen – Response to Staff Survey.

<table>
<thead>
<tr>
<th>Positive feedback</th>
<th>Areas for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>The LNP is always on hand to answer questions, to monitor the staff in their interactions with residents.</td>
<td>Give more protected time to speak with staff.</td>
</tr>
<tr>
<td>To have the programme on the ward brought issues to base. You are reminded of your surroundings, the residents and the way you treat the residents becomes more real and more important than a classroom.</td>
<td>More presence at ward level from time to time by the LNP.</td>
</tr>
<tr>
<td>Small groups are very effective. It is working very well at present.</td>
<td>LNP could randomly ask questions to find out the knowledge of staff on different forms of elder abuse and how to deal with same.</td>
</tr>
<tr>
<td>Doing the questionnaires (KAMA Tool) keeps me sharp and observant of my own behaviour.</td>
<td></td>
</tr>
<tr>
<td>It has helped me to consider how I would deal with various situations if they occurred.</td>
<td></td>
</tr>
<tr>
<td>Case studies (KAMA Tool) very helpful – it gave me more confidence that I would know how to deal with similar situations.</td>
<td></td>
</tr>
<tr>
<td>The frequent Questionnaires (KAMA Tool) gave us a chance to re-visit the various scenarios that we could encounter on any given day at work.</td>
<td></td>
</tr>
<tr>
<td>It supported me in my role with continuing education and updating my staff.</td>
<td></td>
</tr>
<tr>
<td>Performance &amp; Development (Hospital Staff) attending wards to support LNP and Staff was very important.</td>
<td></td>
</tr>
</tbody>
</table>
| **From LNP’s**  
- It has generated a lot of thought.  
- It is a very positive experience.  
- Regular discussions and feedback from staff worked well.  
- As LNP I felt I had the responsibility to lead by example  
- Being an LNP has made me more confident at speaking to other staff members. I feel it has been a positive experience for everyone. | **From LNP’s**  
- If there were questions for Nursing Staff and then other questions for HCA (Health Care Assistant) and Auxiliary Staff. |
Appendix Twenty – NF06 Submissions to HIQA 01/01/15 to 31/03/16

<table>
<thead>
<tr>
<th>Date</th>
<th>Unique Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>13/02/15</td>
<td>313755</td>
</tr>
<tr>
<td>27/04/15</td>
<td>549940</td>
</tr>
<tr>
<td>17/07/15</td>
<td>6657386</td>
</tr>
<tr>
<td>16/10/15</td>
<td>1044943</td>
</tr>
<tr>
<td>12/11/15</td>
<td>340349</td>
</tr>
<tr>
<td>24/11/15</td>
<td>340349</td>
</tr>
<tr>
<td>08/12/15</td>
<td>502518</td>
</tr>
<tr>
<td>11/12/15</td>
<td>357480</td>
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<tr>
<td>22/12/15</td>
<td>429664</td>
</tr>
<tr>
<td>26/12/15</td>
<td>919044</td>
</tr>
<tr>
<td>30/12/15</td>
<td>931344</td>
</tr>
<tr>
<td>02/01/16</td>
<td>346376</td>
</tr>
<tr>
<td>10/01/2016</td>
<td>2042943</td>
</tr>
</tbody>
</table>

01/01/15 – 30/09/15: 3 submissions

01/10/16 – 31/03/16: 10 submissions

01/01/16 – 31/03/16: >300% increase in submissions during the implementation of LNP
Appendix Twenty One – Return on Investment.

Return on Investment = (Gain from investment – Cost of investment)


**Implementation of the Link Nurse Practitioner (Protection of VOA)**

<table>
<thead>
<tr>
<th>Gain</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building evidence knowledge base</td>
<td>One day training programme for each LNP to be developed</td>
</tr>
<tr>
<td>Established link Nurse at ward level</td>
<td>Protected time (20 minutes per fortnight) to deliver staff training on wards</td>
</tr>
<tr>
<td>Working with patients, staff &amp; families</td>
<td></td>
</tr>
<tr>
<td>Creating transparency in service delivery</td>
<td></td>
</tr>
<tr>
<td>Continuous growth and development in practice</td>
<td></td>
</tr>
<tr>
<td>Reinforcing best standards of care in relation to the protection of VOA</td>
<td></td>
</tr>
<tr>
<td>Regular assessment of staff knowledge</td>
<td></td>
</tr>
<tr>
<td>Prevent potential elder abuse cases</td>
<td></td>
</tr>
<tr>
<td>Create reputational credibility in service delivery</td>
<td></td>
</tr>
<tr>
<td>Prevent litigation from potential cases if LNP not in place</td>
<td></td>
</tr>
</tbody>
</table>


Update November 10th, 2015.

- Safeguarding and Protection Teams are now in place, with all of the Principal Social Workers, except one, now in post. The Principal Social Worker on the S&PT in CHO Area 7 is not due to take up the position until 23rd November.
- A designated email address, accessible only by members of the specific S&PTs, has been established in all but three CHO Areas to which all Preliminary Screenings and Safeguarding Plans should be sent. CHO Areas 1, 7 & 8 have technical difficulties in establishing a dedicated email address and efforts are being made to overcome this.
- A temporary logging sheet to be used by all S&PTs has been devised. A small Working Group, comprising PSWs of the S&PTs, staff from the National Safeguarding Office and national IT, has been established to develop a more sophisticated logging and tracking sheet in relation to safeguarding concerns.
- Training of S&PT members complete. Training for Designated Officers and Awareness Raising for frontline staff is ongoing. A Train-the-Trainer programme has been developed and will commence on 26th November. This will allow for accelerated rate of training of Designated Officers and Awareness Raising for frontline staff.
- The original Designated Officer listing is currently being reviewed and updated through each Community Healthcare Organisation and is due for submission to the National Safeguarding Office by 16th November.
- A Reference Group has been established comprising representatives of the National Safeguarding Office, the National Federation of Voluntary Bodies, the Disability Federation of Ireland and the Not-For-Profit Organisations. This Group has been established to support and advise funded agencies on the Policy and to act as a communication and consultative forum.
- A standard Preliminary Screening Form, Referral Form and Safeguarding Plan Form has been developed which has been distributed to all Chief Officers for onward distribution to relevant personnel and agencies within each CHO Area.
- A Checklist, to be used by funded agencies to audit compliance of their policies and procedures with the National Policy, is currently being developed through the Reference Group.
- The National Inter-Sectoral Safeguarding Committee will be formally established and launched in December.
- The Safeguarding and Protection Committees are currently being established in each CHO.
- A dedicated section on Safeguarding has been developed on the Change Hub.
- A Practice Handbook on the Policy is currently in the process of being developed. This will provide assistance to all staff that have a role in safeguarding.
Providers/Persons in Charge
Designated Centres for Older Persons

29 February 2016

Revised National Standards for Residential Care Settings for Older People

Dear Provider/Person in Charge,

The Minister for Health has approved the revised National Standards for Residential Care Settings for Older People. These outcome-based Standards represent a revision of the previously published National Quality Standards for Residential Care Settings for Older People in Ireland.

The revised standards will take effect on 01 July 2016.

Prior to this date, the Authority Safety and Quality Improvement directorate will be initiating a series of provider seminars to ensure you are au fait with the content of the revised Standards, and will be in contact with you in the near future in relation to same.

Yours sincerely,

John Farrelly
Deputy Chief Inspector of Social Services
SAFEGUARDING Newsletter

February 2016

The National Safeguarding Office would like to update and inform you on developments with regard to the on-going implementation of the “Safeguarding Vulnerable Persons at Risk of Abuse – National Policy & Procedures”.

CREATION OF SAFEGUARDING TEAMS IN COMMUNITY HEALTH AREAS

To support the on-going implementation of the “Safeguarding Vulnerable Persons at Risk of Abuse – National Policy & Procedures” dedicated Safeguarding & Protection Teams (SPT) are now in place in each of the nine Community Healthcare Organisations, following the recruitment of additional social workers in 2015.

CONTACTS DETAILS FOR SAFEGUARDING AND PROTECTION TEAMS:

<table>
<thead>
<tr>
<th>CHO Area</th>
<th>Principal Social Worker</th>
<th>Address</th>
<th>Email Address</th>
<th>SPT Team Telephone No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Donna Carroll</td>
<td>HSE Office, 10A Lower Main Street, Buncrana, Co Donegal.</td>
<td>Safeguarding <a href="mailto:cho1@hse.ie">cho1@hse.ie</a></td>
<td>074-9363525</td>
</tr>
<tr>
<td>2</td>
<td>Pauline Levens</td>
<td>La Nua, Castlepark Road, Ballybane, Galway.</td>
<td>Safeguarding <a href="mailto:cho2@hse.ie">cho2@hse.ie</a></td>
<td>091-748488</td>
</tr>
<tr>
<td>3</td>
<td>Maggie McNaught</td>
<td>Tyone Health Centre, Tyone, Nenagh, Co Tipperary.</td>
<td>Safeguarding <a href="mailto:cho3@hse.ie">cho3@hse.ie</a></td>
<td>067-46470</td>
</tr>
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</table>

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Abstract

The implementation of a LNP specifically trained on the protection of vulnerable older adults (VOCA's) supports best practice by promoting elder abuse training with staff development in recognising and responding to the protection of VOCA's. The LNP is expected to complement the Health Service Executive (HSE) two year mandatory training programme on protection by preventing knowledge decay and reinforcing best practice in recognising and responding to all forms of elder abuse.

Rationale: A transgression of standards from the HSE National Policy document on Safeguarding was identified by the organisation's regulator, the Health Information and Quality Authority (HIQA). This became the catalyst for change as mandatory training being received by staff, a transgression of standards had occurred.

Methodology: The HSE change model was used to implement the LNP. The Knowledge and Management of Abuse (KAMA) tool was used to assess staff knowledge pre (KAMA A) and post (KAMA B) implementation of the LNP by face-to-face delivery of case scenario discussion with the LNP and ward staff. This had a dual role of assessing the employee's knowledge post mandatory HSE training and pre LNP input to identify a baseline knowledge.

Evaluation: The Kirkpatrick model was used to evaluate the average return on investment of 71% compliance with the KAMA tool within the project timeframe. A marked improvement of 41% increase in staff knowledge was identified in recognising and responding to elder abuse following the implementation of the LNP. This literature is synonymous with saying that an increase in staff knowledge leads to enhanced protection of VOCA's in residential care.

Conclusion: Lessons learned from the organisational development project are that residential services need to harness the protection of VOCA's by taking direct responsibility for the evaluation of staff training provided. Implementing the LNP with the KAMA tool has demonstrated an increase in the employee's ability to recognise and respond to elder abuse. It prevents knowledge decay which is critical to providing consistent protection.
Safeguarding Vulnerable Older Adults: Implementing a Link Nurse Practitioner (LNP) to Educate Staff and Promote Awareness in Residential Care

Catherine White, MSc Leadership ID: 01139476

catherine.white@اسي; (447) 244.3657

Introduction & Background

The implementation of a LNP specifically trained in the protection of Vulnerable Older Adults (VOAs) followed on from the development of a comprehensive Knowledge & Information and Quality Assurance (KIA) report which identified an unmet need of information. The Health Service Executive (HSE) National Policy Guidelines on the Safeguarding and Protection of Vulnerable Adults stipulates a mandatory training programme every two years for all employees on the protection of VOAs. Despite the training, current reporting of abuse is considered the tip of the iceberg. The LNP is expected to increase staff ability to recognize and respond to all forms of abuse using the Knowledge And Management of Abuse (KAMA) tool. This is a case scenario discussion guide.

Aims & Objectives

The aim - to support best practice by combining abuse awareness training with staff development.

The objectives:

- • Review of policy procedures, guidelines and best practice to include LNP by 01/10/15.
- • Develop a database of staff training awareness by 01/11/15.
- • Identify staff knowledge base using the KAMA tool by 01/10/16.
- • Staff compliance with LNP support identified by 01/02/16.
- • Measure staff knowledge post LNP using the KAMA tool by 01/04/16.

Methodology

The HSE Change Model (Figure 1) was considered the most appropriate model for implementation. As it had the capacity to create a successful change through active engagement, and by building trust, credibility and commitment with the LNP. 1

Figure 1: HSE Change Model

Evaluation

The Kotter model was used to identify the staff motivation and learning. LNP’s were successfully implemented across Ireland with policy development and case bases for staff training needs established. An overall return on investment of 71% correlated with the KAMA tool identified. There was an average 41% increase in staff knowledge awareness (Figure 2).

1. Initiative – The KQA report was the catalyst for change. Preparing to lead change involved brainstorming, brainstorming and key staff to engage.

2. Planning – Communication and planning were critical to the successful implementation of change. Preparing materials and the implementation plan.

3. Implementation – LNP’s were identified and trained and specifically trained on the protection of VOAs. The KAMA tool was used to identify staff knowledge and support learning via scenario case discussion.

4. Mainstreaming – Staff could visualise LNP support on a daily basis. Integrating LNP sessions into a way of working became an important part of this process. Continuous monitoring of practice with LNP in place.

Organisational Impact

Conclusions

The complexities attached to the protection of VOAs cannot be attributed to any one person. The LNP contributed a proactive role in the protection of vulnerable adults in care. In particular, grey areas of practice where there were many.

References

1. HSE Guidelines on the Protection of Vulnerable Adults, HSE
2. HSE Guidelines on the Protection of Vulnerable Adults, HSE
3. HSE Guidelines on the Protection of Vulnerable Adults, HSE
4. HSE Guidelines on the Protection of Vulnerable Adults, HSE
5. HSE Guidelines on the Protection of Vulnerable Adults, HSE
6. HSE Guidelines on the Protection of Vulnerable Adults, HSE