Safeguarding IRELAND

Promoting the rights of adults at risk

REPORT ON PEER-TO-PEER ABUSE:

INFORMING DEFINITIONS AND THRESHOLDS

November 2024

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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Foreword

Safeguarding Ireland welcomes this scoping study into peer-to-peer abuse, an issue that has been recognised as complex and multifaceted for many years in residential health and social care services. Safeguarding Ireland acknowledges that the Health Service Executive (HSE) is concerned about peer-to-peer abuse. The HSE has supported this study and has committed to further research to inform culture, policy and practice into the future. Increasingly, peer-to-peer abuse is recognised as a significant adult safeguarding issue that must be dealt with through evidence-informed policy and practice that assists with the recognition of such abuse and recognition of the key triggers of negative interactions and abuse between service users. Safeguarding Ireland believes the study also highlights the need for clear definitions in such peer-to-peer interactions, what should be reported, including when and to whom, and critically how health and social care services can learn from individual incidents and, more broadly, patterns and trends across services. Safeguarding Ireland is also clear that, in the future development of any policy and practice guidance regardless of context, both abuse and aggression cause harm to the victim and cannot be normalised or tolerated.

Safeguarding Ireland acknowledges that this is an initial scoping exercise that helps provide a greater understanding of the issue from an international and Irish perspective within health and social care services. Through a review of international peer reviewed and grey literature, it provokes a conversation on how peer-to-peer abuse might be defined. One key issue highlighted relates to the capacity of the initiator of the aggression or abuse. It is vital that those involved in development and implementation of policies in this area need to take account of the functional test for the assessment of capacity as set out in the Assisted Decision Making (Capacity) Act 2015.

Safeguarding Ireland also believes that the study highlights that issues of definitions, thresholds and training on peer-to-peer abuse should be considered in the context of the proposed new HSE policy and procedures on adult safeguarding as recommended in its report Moving Forward: Adult Safeguarding in the Health Service Executive (2024).

This study highlights the differentials in the reporting of incidents of potential and actual peer-to-peer abuse across the health and social care services. It is notable that there is comprehensive data and information available from notifications to the Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) from nursing homes and residential services for people with a disability. However, the study also demonstrates the paucity of information from other services provided and commissioned by the HSE. The study endeavoured, through qualitative means, to ascertain the extent of the issues and how they were dealt with in day care and mental health services. Safeguarding Ireland believes that the study points

towards the need for more rigorous, mandatory reporting of such incidents from day care, inpatient, community and residential mental health services under a revised Mental Health Act and revisions in reporting the National Safeguarding Office.

From its establishment, Safeguarding Ireland has acknowledged that adult safeguarding is not just an issue for Ireland's health and social care sector. It needs to be seen as a wider societal issue that should be dealt with by a cross sectoral, whole of Government approach. This study undoubtedly highlights information limitations in respect of non-regulated health and social services are in terms of peer-to-peer abuse. However, there are similar 'blind spots' in services provided and commissioned by other Government departments and their agencies across Ireland. Safeguarding Ireland believes that these include services within the housing sector, including supported living services for older people, people with a disability and those in need of mental health support. Safeguarding Ireland also believe that there are similar vulnerabilities in residential services provided to people experiencing homelessness and those seeking refuge from domestic and gender-based violence. In addition, the state is increasingly providing residential services for people seeking refuge and international protection where issues of peer-to-peer abuse has the potential to occur. Reporting from these settings is further supported in the publication in April 2024 by the Law Reform Commission of its report on *A Regulatory Framework for Adult Safeguarding* which highlights the need for mandatory reporting of harm, ill-treatment, and neglect under proposed legislation.

Whilst acknowledging the insights that this initial study provides, Safeguarding Ireland believes that a further, wider, more comprehensive study should be undertaken to ascertain the extent to which peer-to-peer abuse occurs within those health and social care services not subject of formal regulation and mandatory notifications, and that the research should be similarly extended to residential services provided and commissioned by other Government departments and their agencies.

The terms of reference for this scoping study limited its methodology to the perspectives of providers of residential and day care services. Safeguarding Ireland believes that any future research into this issue should include:

- Data and perspectives of the National Safeguarding Office and the HSE safeguarding teams.
- Engagement with those in receipt of services or relevant self- advocacy groups.
- Further exploration of perceived or actual causes or contributory factors leading to negative peer-to-peer interactions. This could include:
    - Physical environment
    - Staffing and staff-related issues

    - Living arrangements
- The impact of such interactions on other residents.
- Supports and training that may be necessary for staff in preventing, or dealing with the complexity of such interactions.

Safeguarding Ireland believes that it is only with more comprehensive knowledge of the issue and how it is being dealt with within all sectors that policy, procedure, and practice can be developed to effectively deal with on peer-to-peer abuse and its prevention.

Patricia Rickard-Clarke
Chair

Background

About Safeguarding Ireland

The National Safeguarding Committee was established by the Health Service Executive (HSE) in December 2015 in the aftermath of the investigation of the adult abuse issues within the Áras Attracta facility, to bring together the views and perspectives of a multi-sectoral group on how the issue of adult safeguarding could be addressed in health and social care services in Ireland under an independent Chairperson. In 2017, the National Safeguarding Committee evolved into an independent entity, National Safeguarding Ireland CLG., trading as Safeguarding Ireland. Safeguarding Ireland is also a registered charity.

Safeguarding Ireland promotes the safeguarding of adults at risk from all forms of abuse by persons, organisations and institutions. It seeks to enhance inter-sectoral collaboration, develop public and professional awareness and education, and undertakes research to inform policy, practice, and legislation around safeguarding in the Republic of Ireland. Under its current strategy, Safeguarding Ireland Strategic Plan 2022-2025, Safeguarding Ireland has focused on three main objectives:

1) The promotion and pursuit of the introduction and enactment of Adult Safeguarding Legislation.
2) The establishment of an independent over-arching National Safeguarding Authority.
3) Raising public and organisational awareness of issues of abuse, neglect and exploitation and of the need for a rights-informed approach to adult safeguarding issues.

About this report

This report, which is part of an ongoing research agenda designed to raise understanding and awareness on various aspects of adult abuse and also to inform the overarching legislative and governance response, supports all three of these strategic objectives.

In mid-2023, Safeguarding Ireland commenced the development of terms of reference for this research which involved a preliminary review of Irish and international literature, in addition to consultation with Irish and international (members of the 'Five Nations Group on Adult Safeguarding' (UK and Ireland)[1] stakeholders with expertise in relevant areas.

[1] https://safeguardingireland.org/5nations/

While 'peer-to-peer abuse' was identified as an issue that existed across all jurisdictions, the paucity of published and 'grey' literature, was acknowledged, as was the complexity and multi-faceted nature of the issue.

There is no definition of what is meant by 'peer-to-peer abuse'. Therefore, there is no agreed understanding and consistency of interpretation and the need to record or report incidents. It was recognised that the use of the term 'abuse' may not always be appropriate especially as the issues can occur as a result of compatibility issues between residents and service users. It is generally agreed that peer-to-peer altercations are safeguarding concerns, but it is not clear when a peer-to-peer interaction becomes 'abuse'. As a result of the lack of a definition of 'peer-to-peer abuse', training for staff on the issue appeared to be very limited.

There was also a concern that there may be over-reporting of incidents as the current practice would appear to be that service providers report all peer-to-peer interactions as abuse. It was generally felt that clearer definition would facilitate more assessment of the incident and appropriate reporting of safeguarding concerns as opposed to categorising the incident as abuse and reporting it as such.

Notably, it was apparent that some provider organisations operate a threshold system for reporting of such incidents, being selective in what is reported as an incident whilst others report all concerns as abuse.

At times capacity within the residential health and social care sector can lead to providers having to be reactive to emergencies, in terms of the admission of service users into services. At times, a full assessment and access to full information about the person being admitted to the service may not always be possible. This can lead to situations where people move into a residential centre where incompatibility issues can arise.

Against this background, in initiating this research Safeguarding Ireland wished to:

- Undertake a rapid appraisal of what other jurisdictions have published in respect of the topic of 'peer-to-peer abuse' or related concepts within health and social care services.
- Seek to clarify a definition of 'peer-to-peer abuse'.
- Examine the circumstances and settings in which 'peer-to-peer abuse' occurs in Ireland, what data is available from those settings and other sources on the triggers, nature, frequency, management, impact and reporting of such occurrences.
- Examine the existence of current operational policies in Ireland on 'peer-to-peer abuse' noting how such occurrences are reported and whether thresholds are used in reporting and what principles underpin such policies, for example, person centred, human-rights based.

- Make recommendations for further research aimed at influencing policy and practice in care and support settings and with a view to informing adult safeguarding and other relevant legislation.

A formal Request for Tenders was published on safeguardingireland.org and www.activelink.ie in December 2023[2] and following the assessment of tenders received, the Health Information and Quality Authority (HIQA) was commissioned to carry out this research on Safeguarding Ireland's behalf.

About HIQA

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services** — Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.

- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

[2] https://safeguardingireland.org/wp-content/uploads/2023/12/rft-scoping-study-on-the-issue-of-peer-to-peer-abuse.pdf

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health and social care services, with the Department of Health and the HSE.

Summary

This report consists of the findings of a programme of research aimed at informing definitions and thresholds, improving understanding of current reporting practices and available safeguarding policies and improving understanding of frequency and nature of peer-to-peer aggression and abuse in care settings in Ireland.

This programme of research included: a systematic review, a qualitative analysis of statutory notifications of allegations of abuse from nursing homes and residential services for people with disability that are required to be notified to the Chief Inspector of Social Services within the Health Information Quality Authority (HIQA), a telephone survey of day services and mental health services on their experiences of peer-to-peer abuse, a desktop survey of available safeguarding and abuse policies and guidelines and a Delphi study to inform recommendations on a definition and thresholds for peer-to-peer abuse.

Peer-to-peer aggression is a proposed term in the literature that captures the nature of the phenomenon of the low level disputes that occur in services. The use of the term 'aggression' as opposed to abuse removes any assumption that the perpetrator wilfully intended to cause harm whilst also not minimising the impact on the recipient/victim.

Aggression can however transgress to abuse. Identifying a threshold at which an incident transgresses from aggression to abuse is challenging. It requires practitioners to establish that the perpetrator did something intentionally, had capacity to understand their actions, whilst also proving that the incident occurred and met a definition for abuse. Patterns of behaviour should also be accounted for as repeated incidence of aggression can also lead to safeguarding concerns.

Although there were substantial reports of peer-to-peer abuse from all services types included in this research (residential services for people with disability, nursing homes, mental health facilities and day services), most of the interactions were low-level disputes. Notification to An Garda Síochána was rare across all service types and the most common management of an incident approach was to verbally address the situation, suggesting consideration of the incidents as low-level disputes. Without thresholds for what constitutes abuse in place, it is difficult to ascertain whether this low level of serious incidents is due to low levels of peer-to-peer abuse or low levels of recognition of such.

The most common type of peer-to-peer aggression or abuse differed by service types. In disability services, it was psychological, followed by physical. In services for older persons, it was physical. In day services and mental health services it was verbal abuse.

Behavioural and psychological elements of the service user's condition were commonly reported as triggers. This finding reinforces the known need for a person-centred approach to the prevention of incidents.

It was evident that services report incidences of peer-to-peer aggression and abuse to the relevant authorities, there, in fact appears to be an element of over reporting resulting from a difficulty in determining when service user interactions constitute abuse and where individual events would not constitute abuse but a pattern of behaviour over time would. There was an expressed need by participants in this research for a definition and thresholds for peer-to-peer aggression and abuse. Despite the good practice in relation to reporting of the occurrence of an incident, where an occurrence was recognised, there were large discrepancies in the quality of the information recorded about incidents and inconsistencies in both how and what is being recorded.

Although safeguarding training was widely in place across services, specific training on peer-to-peer aggression and abuse was not evident.

These findings on reporting practices, policies and training should be interpreted with caution as they are based on available data and do not account for other documents and practices that may exist that have not been published by organisations.

A Delphi study was carried out to reach consensus on a definition. A Delphi study is a short questionnaire that asks if you agree with a proposed definition and if not, suggest changes. The Delphi study is re-run in rounds, each time altering the definitions using the suggested changes, until agreement is reached by 80% of those involved. The Delphi study has been informed by the results of a large programme of research including a rapid review of definitions of peer-to-peer abuse and approaches to setting thresholds, a review of statutory notifications of allegations of abuse, a survey of day services and mental health services on their experiences of peer-to-peer abuse and an analysis of published safeguarding guidelines and frameworks. The Delphi survey will be conducted online. It should take no more than 30 minutes spread out over a few days, in total. The definition that was agreed was: "Offensive, aggressive and intrusive verbal, physical, sexual, and material interactions between service users that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient/victim".

In terms of a proposal for thresholds, no definitive threshold was arrived at but rather a list of considerations that should be taken into account when determining if an incident or situation constitutes abuse. This list included the need for intention and capacity to understand their actions on the part of the exhibitor, the perception of the recipient/victim, the behavioural history of the exhibitor and environmental

factors such as the supports that have been provided to the exhibitor and their implementation and success.

An important consideration was also highlighted which was that regardless as to whether the incident constitutes abuse by the exhibitor, the recipient/victim suffers abuse and should be safeguarded.

Five recommendations are drawn from this research.

1. Move to the use of two terms, 'peer-to-peer aggression' and 'peer-to-peer abuse'. This would both capture the common low-level incidents that routinely occur in services and the more serious abuse incidents but also allow for differentiation using thresholds (Recommendation 3), enabling appropriate responses to be taken and support given to people using services.
2. Introduce a definition for peer-to-peer abuse based on the following: Offensive, aggressive and intrusive verbal, physical, sexual, and material interactions between service users that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient/victim.
3. Introduce a list of considerations for determining if an incident or situation constitutes abuse that includes the following: the need for intention and capacity to understand their actions, on the part of the exhibitor/perpetrator, the perception of the recipient/victim, the behavioural history of the exhibitor/perpetrator and environmental factors such as the supports that have been provided to the exhibitor/perpetrator and their implementation and success.
4. Develop specific training on peer-to-peer aggression and abuse. This should include the need for a person-centred approach to the prevention of peer-to-peer abuse incidents and the need to separate the concept of abuse by the exhibitor/perpetrator from abuse of the recipient/victim. Any definitions and thresholds agreed on should be used in the development of safeguarding policies.
5. Strengthen reporting requirements to support consistency in information collection and ensure inclusion of detail on severity of incidents, including introducing a system that supports data aggregation and analysis of frequency and severity of incidents.

This study was not able to adequately evaluate certain phenomenon relating to peer-to-peer aggression and abuse. Further research into the areas of triggers, demographics of service users as gender, age or ethnicity, resources of services, and research within other service types such as in homeless hostels, international protection accommodation services and community residential mental health

services, is warranted. In order to get a more accurate picture on the applicability of this topic to non-listed or publicly accessible services a further study similar to this one could be recommended to their regulatory bodies.

Abbreviations

ANOVA	Analysis of Variance
FREDA	Fairness, Respect, Equality, Dignity, Autonomy
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
MHC	Mental Health Commission
NIMS	National Incident Management system
NIRF	National Incident Report Forms
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
SCIE	Social Care Institute for Excellence (UK)
SPT	Safeguarding Protection Team

Section 1 Introduction

Interpersonal difficulties and conflicts may arise when different people come together to live in residential care or spend extended periods of time together in day services. Peer-to-peer interactions that may constitute abuse may include verbal altercations, physical violence, unwanted sexual behaviour, damage to one's property, stealing, withholding monies or psychological abuse such as bullying or threatening behaviour.

Some organisations in Ireland collect information on incidents of peer-to-peer abuse. One organisation, The Health Information and Quality Authority (HIQA), the statutory regulatory body for nursing homes and residential care facilities for children and adults with a disability in Ireland receives notifications of allegations of abuse that describe interactions that involve residents that may constitute abuse. A significant proportion of these allegations of abuse notifications from residential disability services and nursing homes describe interactions between residents. The National Safeguarding Office in the Health Service Executive (HSE) also collect and collate data in relation to notifications and referrals to Safeguarding and Protection Teams (SPTs)[3] of alleged abuse and neglect of vulnerable persons.[4] This includes alleged abuse of a service user relating to another service user or peer.

This research is limited to services that service users either live together or spend prolonged periods of time together. It does not cover services such as supported living where an individual lives alone, as the focus is on peer-to-peer interactions and not wider safeguarding concerns.

It is widely acknowledged that there is a lack of clarity on what constitutes abuse between peers in care, both in terms of the availability of adequate definitions and of objective thresholds. Having clear definitions and thresholds is a necessary prerequisite for safeguarding people that use care services. Definitions and thresholds and related data analysis also support informing policy and legislative change and developing guidance and awareness-raising campaigns.

This report consists of the findings of a programme of research aimed at informing definitions and thresholds, improving understanding of current reporting practices and available safeguarding policies, and improving understanding of frequency and nature of peer-to-peer aggression and abuse in care settings in Ireland.

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[3] The HSE has set up nine Safeguarding and Protection Teams (SPTs), one in each Community Health Organisation (CHO) in Ireland.

[4] https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/nationalsafeguardingofficereport2020.pdf

Section 2 Rapid Review of Definitions of Peer-to-Peer abuse

Introduction

Interpersonal difficulties and conflicts may arise when different people come together to live in residential care. Such peer-to-peer interactions may include verbal altercations, physical violence, unwanted sexual behaviour, damage to or theft of one's property or psychological abuse such as bullying or threatening behaviour. There is no standard definition of peer-to-peer abuse in Ireland nor is there a standard means by which to determine whether peer-to-peer interactions are abusive. Thus, the aim of this review was to identify definitions for peer-to-peer abuse and any criteria used to determine whether an incident constitutes abuse in academic literature and grey literature.

Methods

This was a rapid review. Academic articles published since 2010 (inclusive) were sought. Search terms (Table 1) were entered into the following electronic databases: PubMed, Medline, CINAHL, SocINDEX and PsycInfo. The retrieved articles were uploaded to Covidence and screened for inclusion by one researcher. Inclusion criteria were as follows:

- Published in a peer reviewed journal since 2010 (inclusive)
- Available in English
- Included a definition for peer-to-peer abuse or similar concept
- The setting for the research was any type of residential care service.

In addition, grey literature was sourced from organisations internationally. This was completed through targeted searching of the websites of identified organisations from the following countries: Ireland, Northern Ireland, England, Wales, Scotland, the Netherlands, Canada (Ontario and British Columbia), Australia, Belgium, Denmark, Finland, Germany, Norway and Sweden. The list is comprised of jurisdictions that were considered to have similar health and social care structures to Ireland. This list was originally compiled through consultation with experts and has evolved over time through feedback from similar reviews. Organisations included for review were the regulatory body and any safeguarding organisations in the listed jurisdictions. A search for European or international organisations with an adult safeguarding remit was also completed and any identified organisations included for review.

Table 1 Search terms, review of definitions of peer-to-peer abuse

"peer-on-peer" OR "peer" OR "peer-to-peer" OR "peer on peer" OR "peer to peer" OR "resident-on-resident" OR "resident on resident" OR "resident to resident" OR "resident-to-resident"
AND
"abuse" OR "aggression" OR "violence" OR "harm"
AND
"residential care" OR "nursing home" OR "group home" OR "communal setting"

Data were extracted using the following headings: author, title, journal/website, year of publication, definition for peer-to-peer abuse; text describing criteria used for determining whether an interaction is abusive, aggressive or violent.

A thematic analysis was conducted to identify key and/or recurring concepts included in the identified definitions and thresholds. Available definitions and thresholds were tabulated, grouped by themes. Key findings were summarised narratively. A conclusion focused on similarities and differences between definitions and thresholds was compiled along with a proposed definition/thresholds or choice of definitions/thresholds, based on the evidence.

Results

The search of the electronic databases returned a total of 149 studies, 84 of which were removed as duplicates. Of the remaining 65 studies, four were removed as they were not available in English. Of the 61 abstracts screened, 22 studies were excluded. All of the full texts of the remaining 39 studies were obtained. On full-text review it was determined that 19 did not satisfy the criteria for inclusion, leaving 20 studies eligible for inclusion in the review.

For the grey literature search, websites for all relevant organisations (regulatory bodies or advocacy organisations with an interest in safeguarding) were identified by means of a google search. The websites of 26 organisations were queried by inputting the terms 'peer abuse' and 'resident aggression' into each organisation's search function. Of the 26 websites queried, four websites returned relevant documents (n=4 documents) (Table 2).

The total number of included studies/sources, therefore, was 24. We produced a Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram to describe the search process (Appendix 1).

Table 2 Results of grey literature searches, review of definitions of peer-to-peer abuse

Country	Organisation	Definition found	Threshold or categories found
National organisations			
Ireland	Health Information and Quality Authority	Yes	No
Northern Ireland	Regulation and Quality Improvement Authority	No	No
England	Care Quality Commission	No	No
Wales	Care Inspectorate	No	No
	Healthcare Inspectorate Wales	No	No
Scotland	Care Inspectorate	No	No
	Healthcare Improvement Scotland	No	No
Netherlands	Health and Youth Care Inspectorate	No	No
Canada (Ontario)	Ministry of Long-Term Care	No	No
	Retirement Homes Regulatory Authority	No	No
Canada (British Columbia)	Ministry of Health	No	No
	Office of the Seniors Advocate	Yes	Yes
Australia	Aged Care Quality and Safety Commission	No	No
	Australian Commission on Safety and Quality in Health Care	No	No
	Australian Law Reform Commission	Yes	Yes
Belgium	Flemish Agency for Care and Health	No	No
	Walloon Agency for Health and Social Action	No	No
	Federal Public Service - Health, Food Chain Safety, and Environment	No	No
Denmark	Ministry of the Interior and Health	No	No
Finland	Ministry of Social Affairs and Health	No	No
Germany	The Federal Ministry of Health	No	No
Norway	The Ministry of Health and Care Services	No	No
Sweden	Socialstyrelsen	No	No
EU/International organisations			
UK	Social Care Institute for Excellence (SCIE)	Yes	Yes
EU	European Commission	No	No
	European Partnership for the Wellbeing and Dignity of Older people	No	No

Definitions

Twenty-three of the included studies/sources included definitions (Table 3). There were 10 different, but closely related phenomena, for which definitions were provided in the included studies. The term used most frequently (n=10) was 'resident-to-resident aggression'.[1-10] Sources that used this term principally cited two different papers (Rosen et al, 2008; McDonald et al, 2015) as the source of the definition, albeit that the definitions are almost identical. One paper[3] included a quoted definition but cited two papers, one of which did not appear in its citation list. Both 'resident-to-resident violence'[11-13] and 'peer violence or bullying'[14-16] featured on three occasions. 'Resident-to resident elder mistreatment' was referenced in two studies.[17, 18]

There was one source for each of the following terms:

- aggression between persons in care[19]
- peer abuse[20]
- resident-to-resident abuse[21]
- resident-to-resident abuse or aggression[22]
- resident-to-resident sexual aggression[23]

Table 3 Retrieved definitions and sources, review of definitions of peer-to-peer abuse

Term defined	*Author(s)*	*Year*	*Title*	*Definition source*	*Definition*
Resident-to-resident aggression (RRA)	Baumbusch et al.[9]	2018	Family members' experiences and management of resident-to-resident abuse in long-term residential care	Shorted version of Rosen et al. (2008)	Negative and aggressive physical, sexual, or verbal interactions between long-term care residents.
	Botngård, A et al.[1]	2020	Resident-to-resident aggression in Norwegian nursing homes: a cross-sectional exploratory study.	McDonald et al. (2015)	Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.
	Caspi, E et al.[2]	2017	A federal survey deficiency citation is needed for resident-to-resident aggression in U.S. nursing homes.	Apparent combination of both McDonald et al. (2015) and Rosen et al. (2008)	Negative, aggressive and intrusive verbal, physical, material, and sexual interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm in the recipient.
	Faladreau at al. [10]	2023	Resident-to-resident aggression in private seniors' residences	McDonald et al. (2015)	Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.
	Ferrah, N et al.[3]	2015	Resident-to-resident physical aggression leading to injury in nursing homes: a systematic review.	Apparent combination of both McDonald et al. (2015) and Rosen et al. (2008)	Negative, aggressive and intrusive physical, sexual, verbal, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm in the recipient.
	Jain, B et al.[4]	2018	Stakeholder perceptions on resident-to-resident	McDonald et al. (2015)	Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a

			aggression: implications for prevention.		community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.
	Murphy, B et al.[5]	2017	Deaths from Resident-to-Resident Aggression in Australian Nursing Homes.	McDonald et al. (2015)	Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.
	Patchell Bonifas, R et al.[7]	2015	Resident-to-Resident Aggression in Nursing Homes: Social Worker Involvement and Collaboration with Nursing Colleagues.	Rosen et al. (2008)	Negative and aggressive physical, sexual, or verbal interactions between long term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.
	Schiamberg, L et al.[8]	2015	Individual and contextual determinants of resident-on-resident abuse in nursing homes: A random sample telephone survey of adults with an older family member in a nursing home.	Rosen et al. (2008)	Negative and aggressive physical, sexual or verbal interactions between long-term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.
	Myhre, J et al.[6]	2020	Elder abuse and neglect: an overlooked patient safety issue. A focus group study of nursing home leaders' perceptions of elder abuse and neglect.	Rosen et al. (2008)	The authors do not include the text of the definition but cite a paper that provides the following definition: Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient.
Resident-to-resident violence (RRV)	Sifford, KS et al.[11]	2010	Caregiver perceptions of unmet needs that lead to resident-to-resident violence involving residents	Adapted from Patel et al. (1992)	An overt act, involving the delivery of noxious stimuli to another resident that is clearly not accidental.

			with dementia in nursing homes.		
	Sifford-Snellgrove, KS et al.[12]	2012	Victim or Initiator?: Certified Nursing Assistants Perceptions of Resident Characteristics that Contribute to Resident-to-Resident Violence in Nursing Homes.	Patel et al. (1992)	The delivery of noxious stimuli by one resident to others that is clearly not accidental.
	Snellgrove, S et al.[13]	2013	Resident-to-resident violence triggers in nursing homes	Patel et al. (1992)	The delivery of noxious stimuli by one resident to others that is clearly not accidental.
Peer violence or bullying	Mazzone et al.[14]	2018	Bullying and peer violence among children and adolescents in residential care settings: A review of the literature	Kendrick in Barter & Berridge (2011)	The behaviour of one person or group, which causes distress to another person or group as a result of physical threat, assault, verbal abuse or threat.
	Sekol[15]	2013	Peer violence in adolescent residential care: A qualitative examination of contextual and peer factors	Barter et al. (2004)	Any experience of direct or indirect aggression that is likely to cause distress for the victim.
	Sekol et al.[16]	2022	Towards an Integrative Theory of Bullying in Residential Care for Youth	Olweus (1993)	Direct or indirect aggressive behaviour, which is repeated over time, and includes a power imbalance.
Resident-to-resident elder mistreatment (R-REM)	Teresi, J et al.	2013	A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting:	Adapted from Rosen et al. (2008)	Negative and aggressive physical, sexual, or verbal interactions between long term care residents, that (as in a community setting) would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.

			Results from a cluster randomized trial.		
	Woolford, MH et al.[18]	2021	Resident-to-Resident Elder Mistreatment in Residential Aged Care Services: A Systematic Review of Event Frequency, Type, Resident Characteristics, and History	Adapted from Rosen et al. (2008)	Negative and aggressive verbal, physical and sexual interactions between RAC residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical and psychological distress in the recipient.
Aggression between persons in care	Office of the Seniors Advocate (British Columbia, Canada)[19]	2016	Resident-to-Resident Aggression in British Columbia Care Homes	Community Care and Assisted Living Act (2002)	Aggressive behaviour by a person in care towards another person in care that causes an injury that requires – first aid, – emergency care by a medical practitioner or nurse practitioner, or – transfer to a hospital.
Peer abuse	Health Information and Quality Authority[20]	n/a	Health Information and Quality Authority website via search box	Not stated	Abuse that is perpetrated upon one service user by another service user.
Resident-to-resident abuse	Social Care Institute for Excellence (United Kingdom)[21]	2021	Resident-to-resident harm in care homes and other residential settings: a scoping review	Combined attribution to Rosen et al. (2008, McDonald et al (2015) and Teresi et al. (2013)	Negative and aggressive physical, sexual, or verbal interactions between long-term care residents that (as in a community setting) would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.
Resident-to-resident abuse or aggression (RRA)	Joyce, CM et al.[22]	2020	Prevalence and nature of resident-to-resident abuse incidents in Australian residential aged care	Rosen et al. (2008)	Negative and aggressive physical, sexual or verbal interactions between long-term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient.

Resident-to-resident sexual aggression (RRSA)	Rosen, T et al.[23]	2010	Sexual Aggression Between Residents in Nursing Homes: Literature Synthesis of an Under recognised Problem.	Definition proffered within paper	Sexual interactions between long term care residents that in a community setting would likely be construed as unwelcome by at least one of the recipients and have high potential to cause physical or psychological distress in one or both of the involved.

Thresholds

Eleven studies[10, 18, 19, 21, 22, 24-29] included information relevant to what constituted an interaction between peers that was abusive, aggressive or violent, i.e., categories or types. Some were general and others related to specific types of interactions (e.g. sexual abuse/aggression, physical abuse), but could be generally grouped into the following headings: physical, verbal, sexual, material, psychological and other (Table 4). The types of acts included presupposed that they are unwelcome, unwanted or where consent is not evident (for example, touching through clothes, kissing on face or mouth). No studies specifically referred to thresholds or similar for reporting or requiring a safeguarding response.

Table 4 Acts included in types of abusive interactions, review of definitions of peer-to-peer abuse

Type of interaction	**Acts**	
Physical	Biting Bullying Choking Grabbing Hair pulling Hitting with hand/fist Kicking Pinching Poking Pulling	Punching or striking Pushing or shoving Scratching Shaking Slapping Striking or pushing with object Throwing object Tripping Wheelchair ramming Wrestling/scuffling
Verbal	Arguing Insults Screaming	Shouting Swearing Yelling
Sexual	Coerced nudity Digital penetration Exposing/exhibitionism Forcing to view pornography Kissing on face or mouth Inappropriate touching Rape Sexual advance/harassment Touching through clothes	Touching under clothes Sexually explicit photographing Sodomy Unwelcome/suggestive remarks of sexual activity Sexual contact with any person incapable of giving consent
Material	Stealing	Destroying another resident's things
Psychological	Racial slurs	Threats of harm
Other	Invasion of personal space	Violation of resident's privacy

Discussion

There is a substantial, relatively recently published literature on the topic of peer-to-peer abuse in care settings, this is largely based in residential care settings. Of the studies in this review that included a definition for the phenomenon of peer-to-peer abuse, the terminology used was somewhat different. While there were no studies that specifically referred to thresholds, some studies did include the types of acts that were considered to constitute abusive, aggressive or violent interactions. These can be grouped into the following headings: physical, verbal, sexual, material, psychological and other.

None of the included sources used terms such as 'peer-to-peer', preferring to make reference instead to 'resident-to-resident'. The term that likely has the greatest consensus is 'resident-to-resident aggression', with the definition being that set out in McDonald et al (2015): "negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient".[30]

The McDonald paper describes how the definition for 'resident-to-resident aggression' was formulated at a consensus conference of experts, using a modified Delphi approach.[30] The paper also gives context to how the conference deliberated over the distinction made between abuse and aggression the following is a direct extract from that paper:

> "During the feedback process to the entire expert panel, an important point raised across the groups was the selection between the term "abuse" versus "aggression." Some noted advantages to the term "abuse" were that it was thought to be broad in scope, attributes responsibility to the institution, highlights the seriousness of resident-to-resident abuse events, and was grounded in the field of elder abuse and mistreatment. Conversely, there were some concerns that using the term abuse implies intent on the part of the initiator, which might not be the case in situations where the perpetrator lacks capacity (e.g., as seen with dementia residents). Also, there may be concerns that introducing the term in a regulatory environment would lead to stigmatization, contribute to under-reporting issues, and might raise ethical concerns related to its study (e.g., collecting data from vulnerable populations). The term "aggression" was deemed more context-specific, more neutral, and less stigmatizing than "abuse." As well, it does not imply intent. However, a concern with using the term "aggression" was that it might dilute the problem of elder abuse, which many of the participants reported striving to raise awareness about to the larger community."[30]

The deliberation described above underlines the difficulty in framing this phenomenon, where one attempts to balance the rights of service users to be free from abuse and exhibitors/perpetrators who may lack capacity to understand the outcome of their actions.

While the definition above was devised in the context of nursing home care, there is nothing that limits its application to other forms of care. Age or cognitive capacity are not specified and the setting (long-term care) can be applied to most forms of residential care or day services. As such, there is no impediment to using this definition for a wide range of services, albeit 'resident' may need to be changed to 'service user' or other suitable term.

There were a range of acts in the literature that may fall under the umbrella of aggression. The acts are described above but are likely not be an exhaustive list. It is important to note that each act may constitute both aggression/violence and abuse. As discussed earlier, the distinction lies in whether the exhibitor/perpetrator of the act did it intentionally and had the capacity to understand what they were doing. For example, a resident who lack capacity who touches another resident inappropriately may be an example of resident-to-resident aggression. Conversely, where a resident has capacity to understand their action, punches another resident, this may be considered resident-to-resident abuse.

Conclusion

The term 'resident-to-resident aggression' appears to be the most appropriate and commonly used, in the context of negative interactions between people living in residential care. The definition provided for this in the McDonald paper[30] is likely the most appropriate as a result of the means through which it was devised and it's general acceptance in literature. There is scope to alter it slightly to encompass other service types such as day services.

While there were no specific thresholds outlined in the literature with respect to what constitutes resident-to-resident or peer-to-peer aggression or abuse, there were many examples of the types of acts that fall under the definition. There were many acts that can potentially constitute aggression and an important consideration in whether it constitutes abuse is the capacity of the exhibitor/perpetrator to understand their actions at the time of the incident. Capacity in itself is nuanced in that there is a distinction between lacking capacity in an absolute sense and lacking some capacity or capacity sometimes or capacity in relation to some types of decisions. This nuance should also be considered in determining if an act is abusive.

Section 3 Analysis of notifications of allegations of abuse received by the Chief Inspector of Social Services

Introduction

Designated centres in Ireland are required to submit statutory notifications of allegations of abuse[5] to the Chief Inspector of Social Services, in HIQA. The Database of Statutory Notifications from Social Care in Ireland contains all notifications received by the Chief Inspector in HIQA from designated centres for people with disability and designated centres for older persons dating from 2013. It is an anonymised, analysable database. An open access version is available to the public; however, a more detailed version is available internally to HIQA staff. The following analysis was undertaken in order to provide a deep insight to the nature of reported peer-to-peer abuse notifications. The internal database was used to conduct this analysis of the circumstances and settings of peer-to-peer abuse in designated centres in Ireland using its three-day notifications.[6] Three-day notifications refer to single incidents or events that are required to be notified to the Chief Inspector within three working days of their occurrence. Content included in the notifications includes type of service, size of service, staff numbers, nursing numbers, staff to resident ratio, location of service, description of the incident, description of the management of the incident, comment from the inspector, risk rating of the incident, alleged perpetrator, whether the Gardaí[7] were notified and the type of incident.

The aim was to deepen understanding of the phenomenon of peer-to-peer abuse which can be used to inform awareness raising campaigns, training, educational material and give context when discussing policy and legislation development.

Methods

A mixed-methods study was conducted to explore the nature, management, reporting and risk of notifications of allegations of peer-to-peer abuse.

The study was limited to the last four available years of data, 2019 to 2022. This was to account for changes in reporting systems, introduction of new guidance and to ensure that the findings reflect the current situation in Ireland. 2023 data are not yet fully available as notifications for a full year are extracted at the end of quarter

[5] Notifications of allegations of abuse include suspected or confirmed incidents.
[6] The internal version of the database can be requested for use from lens@hiqa.ie and shared under a data sharing agreement.
[7] There are legal obligations to report to An Garda Síochána under the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012

one the following year. This is to allow for retrospective notifications to be submitted and notifications to be closed by an inspector.

First, a quantitative analysis of the frequency of notifications of allegations of abuse and of notifications of peer-to-peer abuse from designated centres for older persons (nursing homes) and designated centres for people with disability for four years (2019-2022) was conducted. The incidence of notifications of all abuse and of peer-to-peer abuse, adjusted for bed numbers in service to facilitate comparisons across years and service characteristics, was also calculated. An analysis of service characteristics and the association with peer-to-peer abuse notifications using an ANOVA was undertaken. Service characteristics included service type, size of service, staff numbers and staff to resident ratio were also conducted.

Second, a thematic analysis of the content was completed to provide context for the statistical analysis and explore the nature and management of the notifications. Types of abuse were identified; an analysis of the 'other' category was conducted and types of abuse specific to resident-to-resident aggression/abuse were outlined. Alleged perpetrators were identified along with a qualitative hand search of free text to explore the perpetrators reported in the 'other' and 'unknown' categories. Peer-to-peer is reported under 'other' and, as such, we conducted an analysis of peer-to-peer abuse as a proportion of other and of total. We reviewed free text in notifications of peer-to-peer abuse for triggers and summarised narratively the findings. We evaluated the number of peer-to-peer notifications that were reported to the Gardaí as a proxy for perceived seriousness of the incident.

Results

Frequency of notifications of abuse

The number of notifications of abuse increased in both residential disability services and nursing homes in the period 2019 to 2022 (Figure 1). Notifications of abuse as a proportion of all 3-day notifications, however, decreased in both disability services and nursing homes over the same period. An increase in notifications of unexpected deaths was identified as inflating the years 2020 to 2022 and distorting the interpretation of notifications of abuse as a proportion of all 3-day notifications, as such the analysis was repeated, excluding notifications of unexpected deaths from the total (Figure 2). This increase may be explained by the COVID-19 pandemic which exacerbated the number of deaths in populations particularly those who were vulnerable due to pre-existing health conditions. When notifications of unexpected deaths were excluded, no substantial change in the proportion of notifications of abuse to total was observed.

Figure 1 Frequency of notifications of abuse and proportion of 3 day notifications

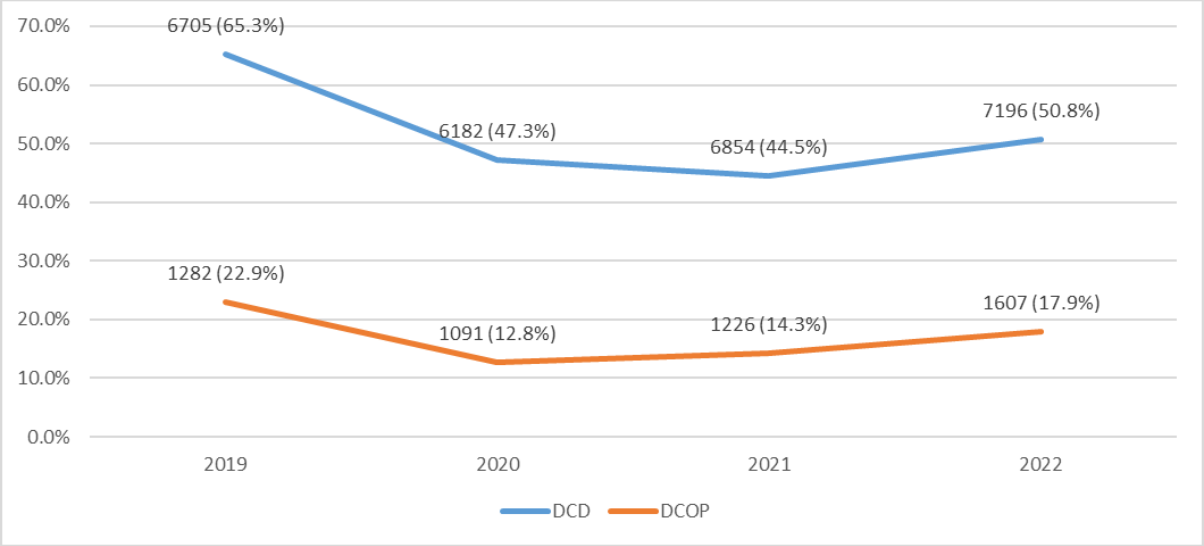
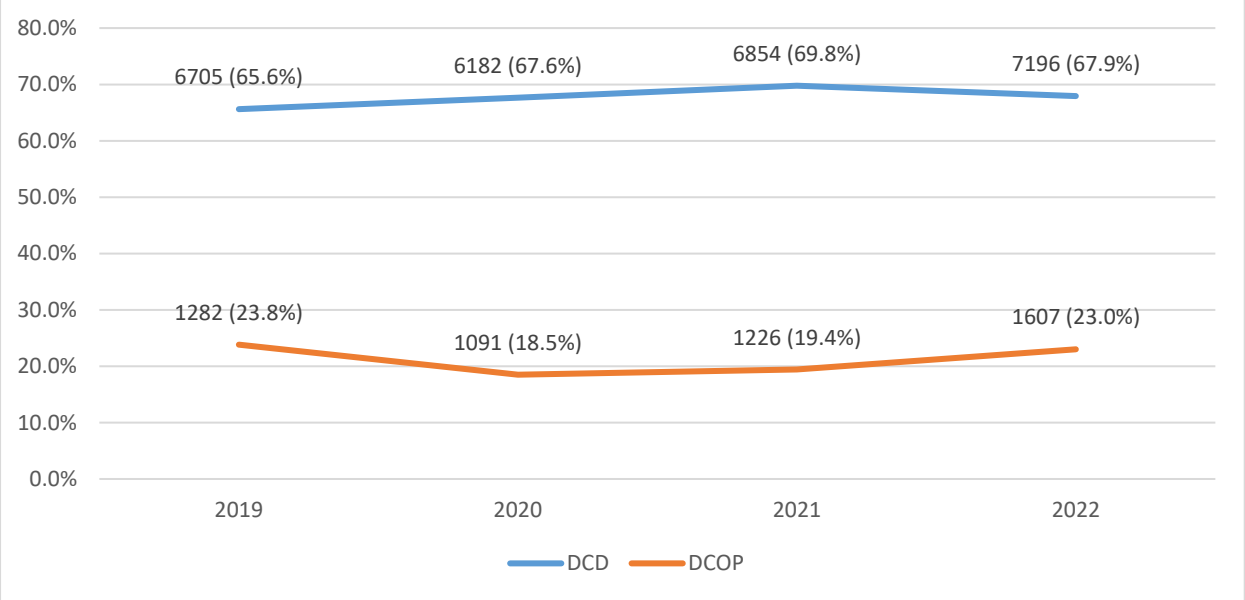
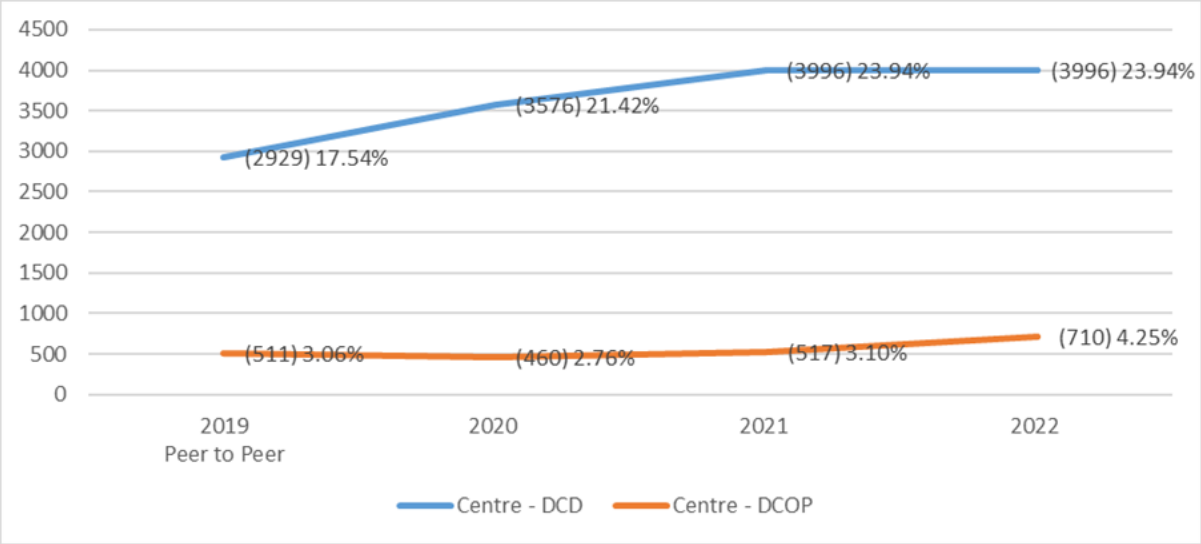


Figure 2 Notifications of abuse as a percentage of all 3-day notifications – notifications of unexpected deaths excluded



Notifications of peer-to-peer abuse increased over the examined period of 2019-2022 slightly in disability services and nursing homes and as a proportion of total abuse notifications (Figure 3).

Figure 3 Notifications of peer-to-peer abuse as a percentage of total abuse notifications (2019-2022)



Incidence of notifications

Incidence is different from frequency in that it accounts for the number of residents. The more residents there are, the more opportunity there is for the occurrence of an event. As such, frequency and proportion can be misleading, whereas incidence removes the bias in comparisons based on baseline numbers in cohorts. Incidence is calculated as the frequency of notifications divided by the number of registered beds. In this case, it is expressed as incidence per 100 beds to enable direct comparison between groups and over years.

The mean incidence (frequency of notifications of abuse/no. of registered beds) per service across the four years was calculated. Table 5 describes the mean, median and interquartile range of the mean incidence, by service type. Designated centres for people with disabilities reported vastly more notifications of abuse than nursing homes (80.5 per 100 beds versus 3.2 per hundred beds). An ANOVA was carried out to test for differences in mean incidence of incidence of notifications across each of the four years (2019-2022), for each of disability services and nursing homes (Table 6). There was no difference observed in the mean incidence of abuse notifications (mean here refers to the average across centres) across the four years for disability services. There was a significant difference across the years for nursing homes (p-value = 0.004), this difference was identified as being between the years 2020 and 2022 for nursing homes, that is to say, the incidence of notifications of abuse was significantly higher in 2022 compared with 2020 but there was no difference between the other year comparisons.

Table 5 Incidence of notifications of abuse (2019 to 2022)

Service	Mean incidence per 100 beds	Median per 100 beds	1st Quartile (25th percentile)	3rd Quartile (75th percentile)
Disability services	80.5	33.3	7.1	91.7
Nursing homes	3.2	1.8	0.4	4.2

Table 6 Incidence of notifications of abuse per year by service type (2019 to 2022)

Service	2019	2020	2021	2022	P-value
Disability services	76.2	74.1	83.7	84.5	>0.05
Nursing homes	3.1[a]	2.7[ab]	3.0[a]	3.8[ac]	0.004

The mean incidence (frequency of notifications of peer-to-peer abuse/no. of registered beds) per service across the four years was calculated. Table 7 describes the mean, by service type. Disability services reported vastly more notifications of abuse than nursing homes (34.0 per 100 beds versus 3.2 per hundred beds). An ANOVA was carried out to test for differences in mean incidence of incidence of notifications across each of the four years (2019-2022), for each of disability services and nursing homes (Table 8). There was a significant increase in the mean incidence of notifications (mean here refers to the average across centres) across the four years for disability services (p=<0.001). There was no significant difference across the years for nursing homes (p=0.659).

Table 7 Incidence of peer-to-peer abuse notifications (2019-2022)

Service	Mean incidence per 100 beds	Median per 100 beds
Disability services	34.0	25.3
Nursing homes	3.2	2.6

Table 8 Incidence of peer-to-peer notifications of abuse by year by service type (2019-2022)

Service	2019	2020	2021	2022	P-value
Disability services	23.02	30.83	39.95	43.58	<0.001
Nursing homes	6.21	3.17	3.09	3.63	0.659

Differences in incidence of peer-to-peer abuse by service characteristics

There were significant differences (p>0.005) in the incidence of peer-to-peer abuse across all service characteristics examined (Table 9). Higher incidence of peer-to-peer abuse were observed in disability services than in nursing homes, in services with more staff, in services with high staff to resident ratios and in services with higher bed numbers.

Table 9 Analysis of differences in incidence of peer-to-peer abuse by service characteristics

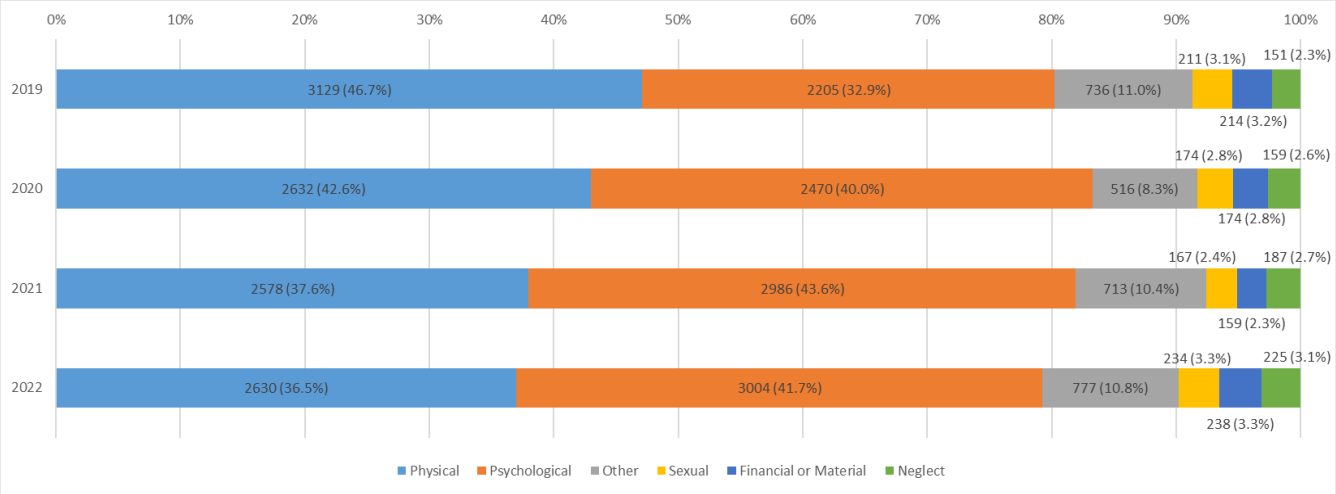
	Mean incidence			
	Disability services	**Nursing homes**	**p-value**	
Service Type	1.48	0.05	0.000	
	Mean incidence			
	Small	**Medium**	**Large**	**p-value**
Staff full time equivalent	0.54	1.23	1.44	0.000
	Mean incidence			
	Low	**Medium**	**High**	**p-value**
Staff to Resident Ratio	0.55	1.22	1.44	0.000
	Mean incidence			
	Small	**Medium**	**Large**	**p-value**
Beds	0.54	1.09	1.48	0.000

Types of Abuse

The notification of abuse form asks for the specification of a one of 10 subtypes of abuse. The following breaks down notifications of abuse into these predefined subtypes.

In disability services the largest type of notification was physical abuse, followed by psychological (Figure 4). Together these accounted for circa 80% of notifications of abuse each year. Notifications of sexual abuse contributed a small proportion (2.4 to 3.3%) to total abuse notifications over the four years. There was little change in the contribution of types of abuse to total notifications of abuse over the four years.

Figure 4 Types of abuse in notifications of abuse, as reported from disability services (2019-2022) *

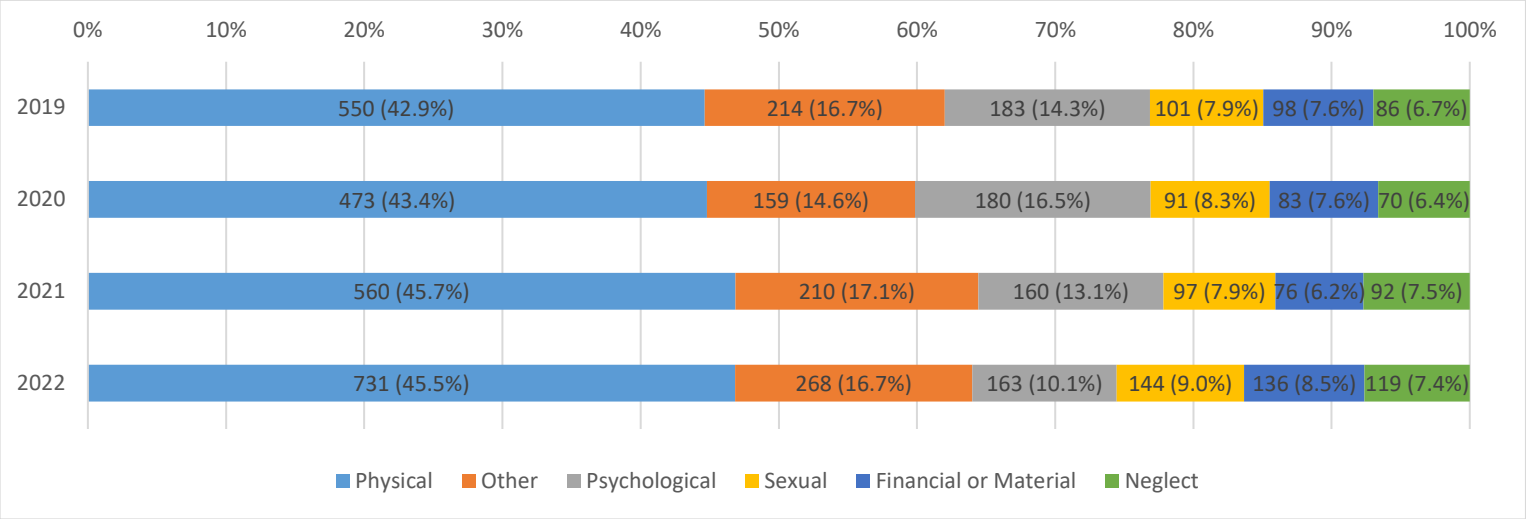


* The bottom four types of abuse (Act of omission, violation of personal integrity, institutional violence, discriminatory) were omitted for ease of reading, each were below 0.5% of total.

In nursing homes, the largest type of notification of abuse was physical abuse, followed by other and then psychological (Figure 5). Notifications of sexual abuse contributed a small proportion (7.9 to 9%) to total abuse notifications over the four years. There was little change in the contribution of the different types of abuse, as reported from nursing homes, over the four years.

It is worth noting that the percentage contribution of sexual abuse notifications was substantially higher in nursing homes than in disability services, however, in terms of absolute numbers, more notifications have been received from disability services (mean of four years: 197) than nursing homes (mean of four years: 108). This is particularly important given the lower number of residents in disability services.

Figure 5 Types of abuse in notifications of abuse, as reported from nursing homes (2019-2022) *



* The bottom four types (Act of omission, violation of personal integrity, institutional violence, discriminatory) were omitted for ease of reading, each were below 2% of total.

'Other' featured as a large contributor for both disability services and nursing homes, as such a qualitative analysis of the contents of the "other" category was carried out.

A sample (n=48) from the 'Other' subtype in order to determine the types of abuse contained in this category was taken. This sample was proportionally representative; it contained notifications from disability services and nursing homes, all risk rating colours and from all years from 2019 to 2022. The categories identified within 'Other' were generated by the research team based on reading of the free text within individual notifications.

The largest category identified in our sample of 'Other' was verbal abuse, which is a form of psychological abuse (Table 10). Notifications detailing multiple types of abuse and physical abuse were also identified as a substantial proportion of 'Other'. There were some differences between disability services and nursing homes in the contributions.

Table 10 Types of abuse in the "other" subtype of notifications of abuse

Type	Nursing homes (n)	Disability services (n)	Total (n)
Verbal	3	12	15
Multiple types listed	5	4	9
Physical	4	4	8
Neglect	1	3	4
Not applicable	0	4	4
Sexual	1	2	3
Psychological	0	3	3
Financial or material	0	1	1
FREDA violation (autonomy)	0	1	1
Total	14	34	48

The analysis of types of abuse was repeated, limited to peer-to-peer notifications only. The results for types of abuse of the peer-to-peer notifications were very similar to that of the total abuse notifications. Psychological abuse was the highest for disability services followed by Physical (Table 11). Physical was the most prevalent of the notification type for nursing homes. Sexual, Psychological and Other were also reported but to a lesser extent (Table 11).

Table 11 Type of peer-to-peer abuse by service type (total n=16748)

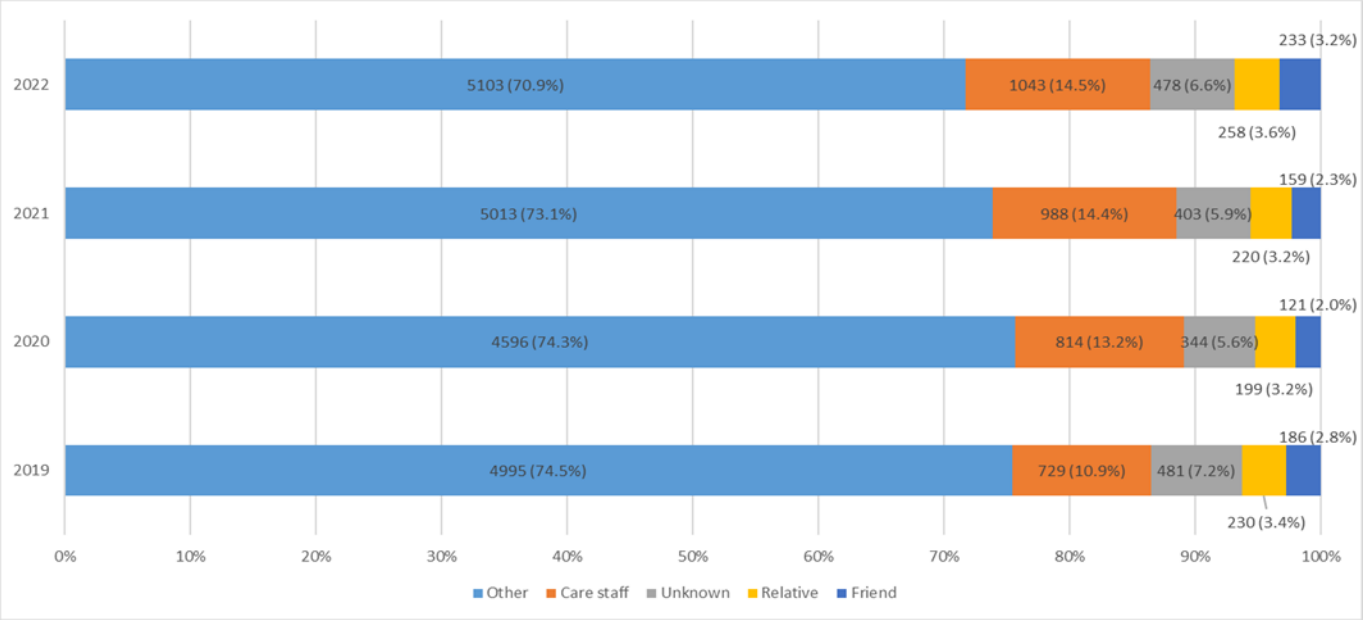
Type	Disability services (n)	Disability services (%)	Nursing homes (n)	Nursing homes (%)	Total (n)	Total (%)
An act of omission	3	0.02%	0	0.00%	3	0.02%
Discriminatory	9	0.05%	1	0.01%	10	0.06%
Financial or Material	150	0.89%	9	0.05%	159	0.95%
Neglect	8	0.5%	3	0.2%	11	0.07%
Other	1259	7.51%	249	1.48%	1508	8.99%
Physical	6052	36.09%	1512	9.02%	7564	45.10%
Psychological	6771	40.38%	176	1.05%	6947	41.43%
Sexual	256	1.53%	223	1.33%	479	2.86%
Violation of integrity	45	0.27%	22	0.13%	67	0.40%
Institutional Violence	17	0.10%	5	0.03%	22	0.13%
Total	14553	86.88%	2195	36.12%	16748	100%

Alleged perpetrator

The Notifications of Abuse form asks for the specification of the alleged perpetrator using one of five predefined categories.

In disability services, the largest proportion of perpetrators was "other", followed by care staff (Figure 6). There was little change in the proportion of perpetrators over the four years.

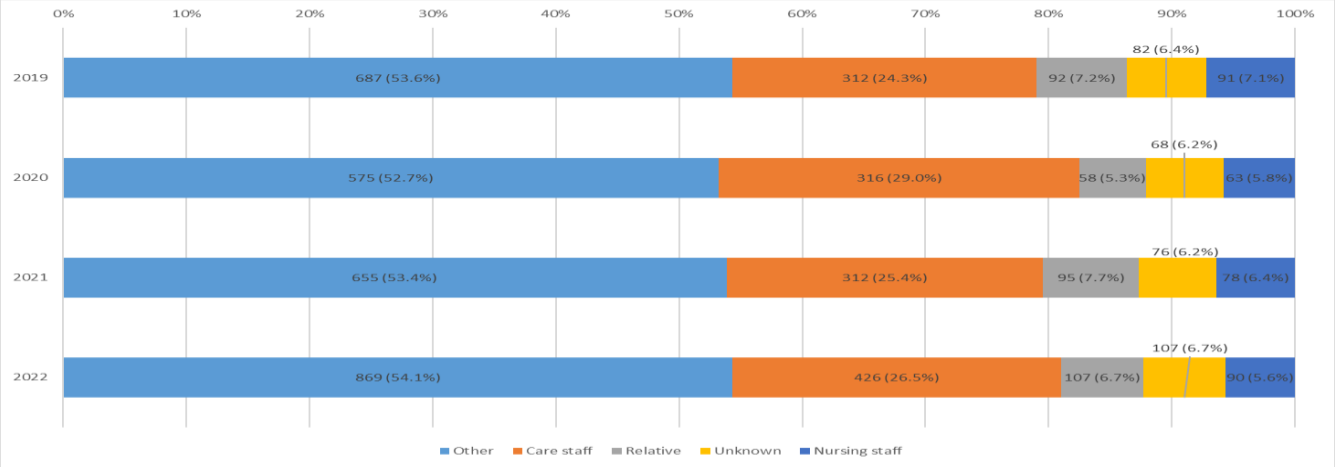
Figure 6 Alleged perpetrator in received notifications of abuse from disability services*



* The bottom 4 types (Nursing staff, volunteer, admin staff and visiting consultant) were omitted for ease of reading, each were below 1.5% of total.

In nursing homes, the largest proportion was also "other" followed by "care staff". There was also little change in the contributions of the categories of perpetrators across the four years (Figure 7).

Figure 7 Alleged perpetrator in received notifications of abuse from nursing homes*



* The bottom 4 types (Volunteer, admin staff, friend and visiting consultant) were omitted for ease of reading, each were below 1.5% of total.

As outlined above in the figures, there are 'Other' and 'Unknown' types of perpetrators of abuse reported. As such, a qualitative analysis of the two categories was conducted in order to better inform the interpretation of the results.

A proportionally representative sample was taken from the 'Other' category (n=102). The sample contained notifications from disability services and nursing homes, all risk rating (overall risk of the event/incident to residents) and from all years from 2019 to 2022. Categories of the types within 'Other' in the sample were determined by the research team by reading of all the free text in the notifications in the sample.

The largest group of perpetrators in the 'Other' category was 'peer' (72.5%), 66.7% for nursing homes and 73.8% for disability services (Table 12). The other categories were very small in comparison. This was the same across disability services and nursing homes.

Table 12 Types of perpetrator in the "other" perpetrator category of notifications of abuse

Person	**Disability services n (%)**	**Nursing homes n (%)**	**Total n (%)**
Peer	12 (66.7%)	62 (73.8%)	74 (72.5%)
NA*	1 (5.6%)	13 (15.5%)	14 (13.7%)
Staff	2 (11.1%)	2 (2.4%)	4 (3.9%)
Self-injurious behaviour	2 (11.1%)	2 (2.4%)	4 (3.9%)
Relatives	1 (5.6%)	1 (1.2%)	2 (2.0%)
Member of public	0 (0.0%)	2 (2.4%)	2 (2.0%)
Volunteers	0 (0.0%)	1 (1.2%)	1 (1.0%)
Multiple people	0 (0.0%)	1 (1.2%)	1 (1.0%)
Total	**18**	**84**	**102**

*NA: Not applicable

Of the 'Unknown' category, a sample of 450 notifications was taken. The free text of these notifications contained additional details that facilitated identification of the perpetrator by the research team.

Eight categories were identified by the research team as summarising the contributing categories of perpetrators within the overarching defined categories of 'Unknown' (Table 13). Most of the notifications identified as "Unknown" remained unknown after qualitative analysis. The next largest proportion of perpetrators within this category was 'member of the public'.

Table 13 Types of perpetrator in the "unknown" perpetrator category of notifications of abuse

Person	**n (%)**
Unknown	400 (88.8%)
Member of the public	20 (4.4%)
Self-injurious behaviour	17 (3.7%)
Staff	9 (2.0%)
Volunteer	1 (0.2%)
Teacher	1 (0.2%)
Relative	1 (0.2%)
Friend	1 (0.2%)
Total	**450**

We also examined peer-to-peer notifications of abuse in the total sample as a proportion of other and of total notifications (Table 14). Peer-to-peer abuse contributed to a large proportion of total notifications in disability services (45%) but less so in nursing homes (7%).

Table 14 Peer-to-peer notifications of abuse as a proportion of "other" perpetrator and of all perpetrators, split by service type

	n of Other in disability services	**n of Other in nursing homes**	**% of Other in disability services**	**% of Other in nursing homes**	**% of total notifications in disability services**	**% of total notifications in nursing homes**
Peer-to-peer	14497	2198	64.45%	9.77%	45.10%	6.83%
Total	19707	2786	100%	100%	100%	100%

Triggers

There were no data collected specifically about triggers. In order to identify possible triggers for the peer-to-peer abuse, a hand search of the free text description of the incident provided for each notification was carried out. A sample of 200 notifications was used to identify patterns and triggers.

There were no distinct patterns within the sample. There were some more frequent triggers. These included environmental factors such as loud noises and shouting, mental health issues and their progression, difficulties communicating or rationalising, and change in medication.

An Garda Síochána Notified

Where Gardaí are notified as part of an incident of abuse, it can provide insight into the level of seriousness of said incident.

In order to identify how many peer-to-peer notifications resulted in the Gardaí being notified we analysed the free text description provided and identified whether the Gardaí were notified or not for disability services and nursing homes separately (Table 15). 1.9% of disability service cases and 3.2% of nursing home cases resulted in the Gardaí being notified. As this was a free text search some were unclear - these are accounted for as "unclear" n=49, 0.3%.

Table 15 Gardaí notified in peer-to-peer abuse notifications (n=16,770)

Disability services		**n**	**%**
	Unclear	49	0.3%
	Contacted	275	1.9%
	Not contacted	14246	97.8%
	Total	14570	100%
Nursing homes			
	Contacted	72	3.2%
	Not contacted	2128	96.8%
	Total	2200	100%

To further understand the peer-to-peer abuse notifications that resulted in notification of Gardaí, we examined a sample of the notifications (n=347) to distinguish the types of abuse that were reported to the Gardaí (Table 16). The largest proportion were physical interactions in both disability services (60%) and nursing homes (43%). Psychological abuse was the second largest proportion in disability services (29%). Sexual abuse was the second largest proportion in nursing homes (39%).

Table 16 Gardaí notified in peer-to-peer abuse notifications abuse type (n=347)

Type of abuse	**n**	**Percentage**
Financial or Material	**8**	**2.31%**
Disability services	8	2.91%
Nursing homes	0	0%
Institutional violence	**1**	**0.29%**
Disability services	1	0.36%
Nursing homes	0	0%
Other	**16**	**4.61%**
Disability services	7	2.54%
Nursing homes	9	12.50%
Physical	**195**	**56.20%**
Disability services	164	59.64%
Nursing homes	31	43.06%
Psychological	**85**	**24.50%**
Disability services	81	29.45%
Nursing homes	4	5.56%
Sexual	**42**	**12.10%**
Disability services	14	5.09%
Nursing homes	28	38.89%

Conclusion

This analysis sheds light on the incidence and frequency of peer-to-peer aggression/abuse in residential disability services and residential services for older persons (nursing homes), regulated by the Chief Inspector of Social Services.

Incidence of peer-to-peer abuse increased between the years 2019 and 2022 in disability services but there was no discernible difference year on year in nursing homes. It is not clear as to whether this increase relates to more vigilant reporting or an increase in occurrence. This increase may have been contributed to by the publication in December 2019 of the National Standards for Adult Safeguarding written by HIQA in partnership with the Mental Health Commission (MHC). This publication may have accounted for a raise in awareness and thus reporting specifically in disability services who had not been recording incidences for as long as centres for older persons.

There was a clear association between the characteristics of a service and the incidence of peer-to-peer abuse. Higher incidence of peer-to-peer abuse were observed in disability services than in nursing homes (mean incidence 34/100 beds versus 3.2/100 beds), in services with more staff, in services with higher staff to resident ratios and in services with higher bed numbers. This should be interpreted with caution as it does not account for the individual needs of the residents in these services. Services with higher staff to resident ratios are likely to have such due to the more complex needs of residents which in turn contribute to the incidence of peer-to-peer abuse.

The most common type of peer-to-peer abuse was psychological in disability services, followed by physical. In services for older persons, it was physical.

There were no distinct patterns for triggers identifiable in the data. There were some triggers mentioned - these included, loud noises, shouting, mental health issues, difficulty communicating and changes in medication.

Whether the Gardaí were notified about an incident was used as a proxy for severity of incidents. The proportion of incidents of peer-to-peer abuse that was reported to the Gardaí was very low, 1.9% in disability services and 3.2% in services for older persons. These were mostly for physical abuse (56.25%).

Although this analysis is limited to notifications from designated residential centres for older persons and people with disability, it makes use of the most detailed dataset of notifications of abuse in Ireland. Time constraints of the project imposed a limitation on the depth of analysis due to the magnitude of notifications along with the volume of free-text data introducing challenges for simple analysis and interpretation. However, considered sampling was conducted in order to ensure representativeness in the analysis.

Section 4 Survey and analysis of services outside of the remit of the Chief Inspector of Social Services

Introduction

Peer-to-peer abuse can occur in various circumstances and services. In section 3 we analysed services regulated by the Chief Inspector of Social Services which included residential services for older persons and people with disability. Other services where peer-to-peer abuse may occur include day services and mental health services. To complement the analysis of the readily available data of services regulated by the Chief Inspector of Social Services (Section 3), a survey was conducted to focus on day services and mental health services.

Methods

A desktop search was carried out to identify services in Ireland, relevant to the survey inclusion criteria. Day services were identified through the HSE website[8] (n=1202) and mental health services through the Mental Health Commission website[9] (n=66 A sample of services, representative for type of service and size of service was drawn (n=100). A survey was designed (Appendix 2) in order to gather data similar to the data collected from notifications received by the Chief Inspector of Social Services. This design facilitated comparison between the different service types. Previous sections of this report also informed the design of the survey.

The survey was administered by telephone by an experienced researcher. The researcher asked to speak to the person within the services best placed to speak about peer-to-peer abuse incidents and management. The sample of services was contacted progressively, ensuring representation across size of service and type of service, until 25 responses were received. The survey answers were then analysed quantitatively and qualitatively.

[8] Adult Disability Day Service Locations - HSE.ie
[9] Approved Centres | Mental Health Commission (mhcirl.ie)

Results

The completed survey included 25 services (Table 17).

Table 17 Services partaking in the survey

Service Size*	**Day Service**	**Mental Health Service**	**Total**
Large	5	1	6
Medium	6	3	9
Small	5	5	10
Total	**16**	**9**	**25**

*Small = 0-30 places, Medium 30-60 places, Large 60+ places

Frequency

Respondents were asked how frequently peer-to-peer abuse occurred per month in their service (Table 18). There was a wide spread of frequencies, without a discernible pattern. Some respondents reported that it was dependant on the service users present in the service at any one time and, as such, it was difficult to assign a frequency.

Table 18 Frequency of peer-to-peer abuse per month by service type and size

	Day Service, n	**Mental Health Service, n**	**Total, n**
Large	5	1	6
1 every few months	1	0	1
8 per month	1	0	1
12 per month	1	0	1
16 per month	1	0	1
20 per month	1	0	1
24 per month	0	1	1
Medium	6	3	9
1 every few months	0	1	1
4 per month		2	2
8 per month	2	0	2
16 a month	1	0	1
20 per month	1	0	1
24 per month	1	0	1
Dependent on services users at the time*	1	0	1
Small	5	5	10
0		2	2
1 per month	3	1	4
4 per month	1		1
8 per month	1	1	2
Dependent on services users at the time		1	1
Total	16	9	25

*Survey participant responded that it was not possible to put a frequency on the incidence of peer-to-peer aggression or abuse as it is dependent on the service users present in the service at any one time and because their presenting needs vary over time.

Respondents were also asked how often they felt peer-to-peer abuse occurred and were given the options, never, rarely, sometimes or often. There was a notable difference in frequency reported by centres by service type and size (Table 19). Rarely and sometimes were the most common responses from day services. Rarely was the most common response from mental health services.

Table 19 Survey respondents' interpretation of how often peer-to-peer abuse occurs within their service, n services = 25

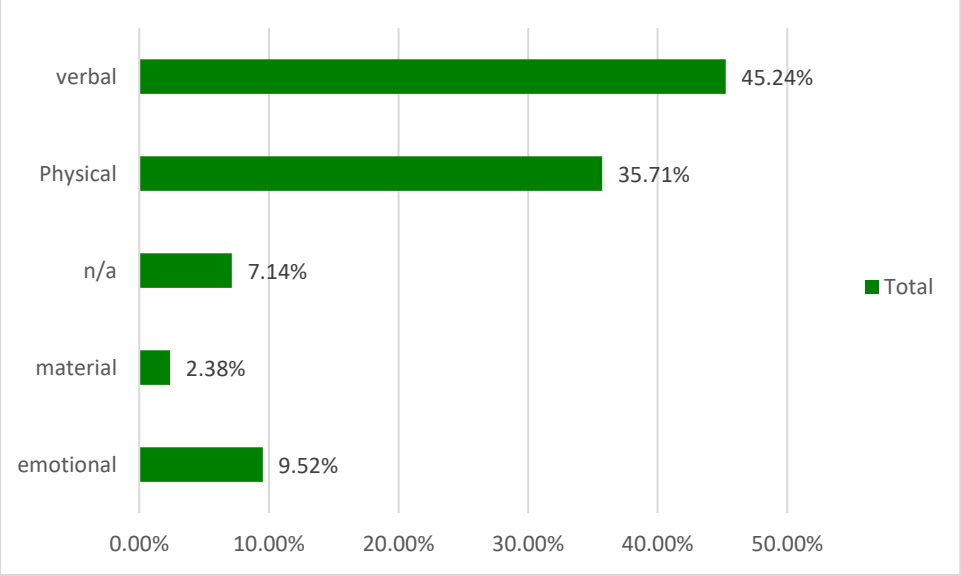
	Never	Rarely	Sometimes	Often
Day Service	8.3%	20.8%	29.2%	8.3%
Large	0%	4.2%	12.5%	4.2%
Medium	4.2%	0%	16.7%	4.2%
Small	4.2%	16.7%	0%	0%
Mental Health Service	0%	16.7%	8.3%	8.3%
Large	0%	0%	0%	4.2%
Medium	0%	0%	4.2%	4.2%
Small	0%	16.7%	4.2%	0%
Total	8.3%	37.5	37.5	16.7%

*Small = 0-30 places, Medium 30-60 places, Large 60+ places

Type of Abuse

Three of the 25 respondents reported no peer-to-peer abuse occurring in their services. Of those that reported peer-to-peer abuse (n=22), verbal abuse was the most prevalent (45.24%) and physical abuse was the second most prevalent (35.71%) (Figure 8). Twelve respondents answered with a combination of types of abuse. These were verbal and physical (n=8), and emotional, verbal and physical (n=4).

Figure 8 Types of abuse as a percentage of total abuse reported by respondents (n=22)

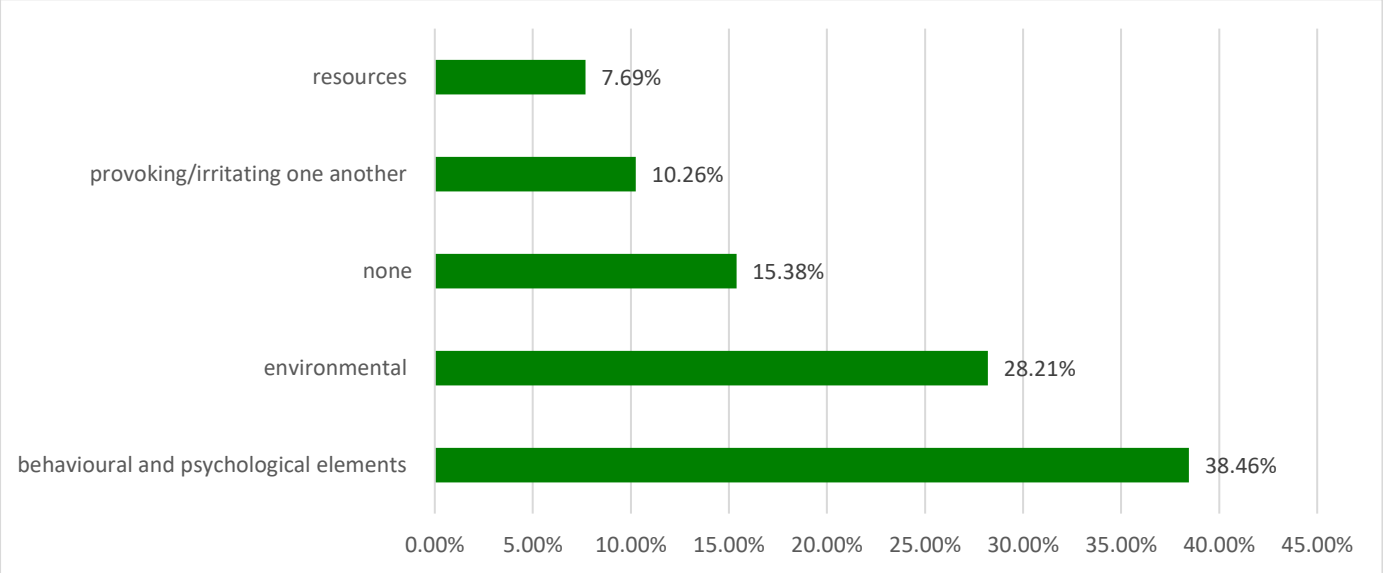


Triggers of incidences

When asked about triggers, six respondents said there were no evident triggers (including the three respondents who reported no peer-to-peer abuse in their services). The remaining respondents (n=19) heavily emphasised that it is very dependent on who is in the service on a particular day and what the behavioural and

psychological markers of their condition may be. Behavioural and psychological elements accounted for 38.46% of types of triggers (Figure 9), followed by environmental factors (28.21%) which includes noise, touch, smell, temperature etc.

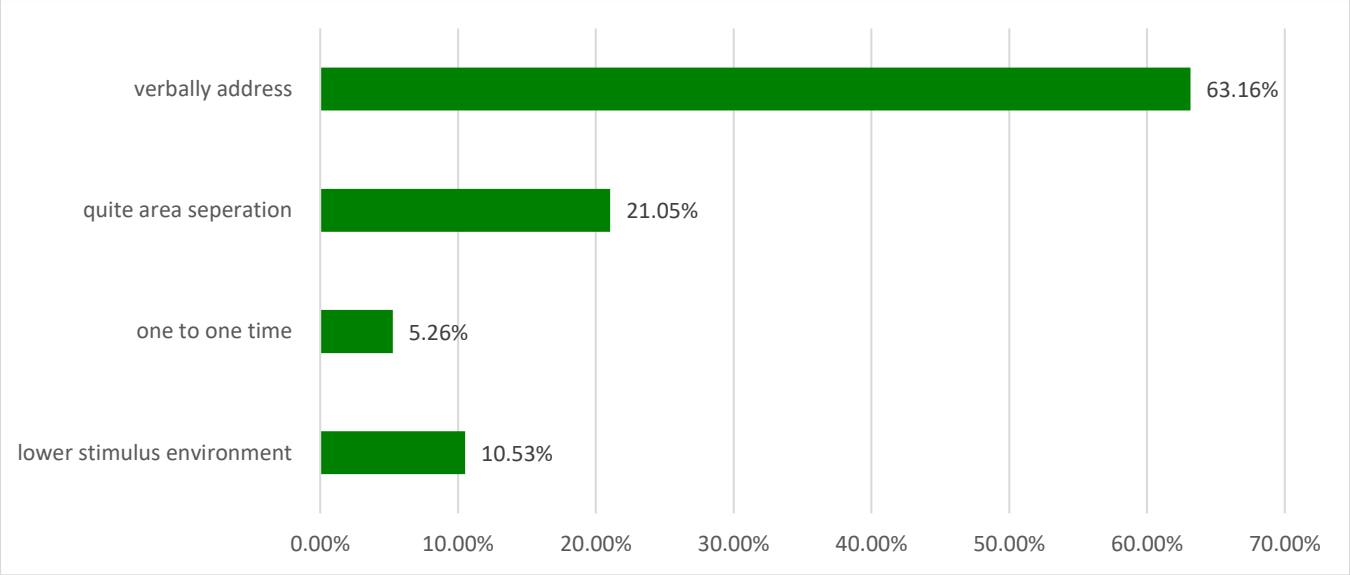
Figure 9 Types of triggers as a percentage of total triggers as identified by participants (n=19)



Management of incidences

All respondents reported there being methods in place for the management of incidents of peer-to-peer abuse in their services. 80% of the respondents reported that their service used multiple methods of management when dealing with incidents of abuse. Verbally addressing the situation was the most common single method used (63%), quiet area separation, one to one time and a lower stimulus environment were used named as methods of management but to lesser degrees (Figure 10).

Figure 10 Management of incidents of abuse as a percentage of total responses (n=25 respondents)



Documentation of incidences

All services included in the survey documented incidents of peer-to-peer abuse. The methods of documentation varied (Table 20). The most used method of documentation was the National Incident Management System (NIMS) using National Incident Report Forms (NIRF).

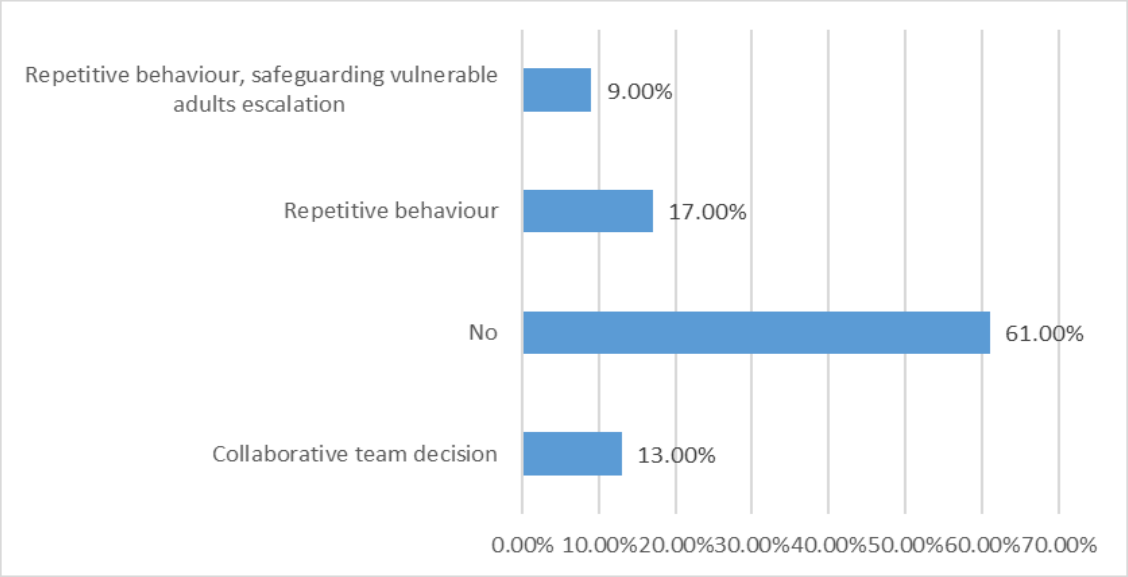
Table 20 Method of documentation of peer-to-peer abuse used in services (n=25 respondents)

Documentation Method	**Count**
NIMS	12
NIMS and clinical files	9
Notes, reviewed by doctor	1
Online system	1
Q pulse online system	2
Total	**25**

Thresholds for aggression

When asked about what threshold is used for aggression and differentiation between different incidences, several individuals expressed the need for a tool or threshold indicator in regard to peer-to-peer abuse. Figure 11 details the methods that are used to attempt to determine a threshold. 60.87% said that they had no method for establishing a threshold for what constitutes abuse. A pattern of repetitive behaviour was the most common consideration taken when identifying if an incident constituted abuse.

Figure 11 Methods used for establishing thresholds between aggression and abuse



Guidelines and Protocols

Respondents were asked if they had any guidelines or protocols that were used within the service regarding safeguarding. A variety of guidelines and protocols were mentioned, with the HSE safeguarding policies, most often used (Table 21).

Table 21 Guidelines and Protocols

Guidelines/Protocol	**n**
Change care plan possibly	1
HSE safeguarding policies	9
Individual risk assessment / policy off hand	1
Mental Health Commission guidelines	2
Mental Health Commission guidelines and HSE safeguarding policies	2
No policy used	6
Safeguarding Ireland	4
Total	**25**

Respondents were asked if they thought the staff to service user ratio impacted on the number of incidents of peer-to-peer abuse. It was generally thought (70%) that there were fewer incidents of peer-to-peer abuse when there was a higher staff to resident ratio.

Table 22 Staff to service user ratio affecting the number of incidents of peer-to-peer abuse

No	30%
Yes, more staff less incidents	70%
Total	**100%**

An Garda Síochána notified

Of the 25 services surveyed, three had contacted Gardaí in relation to peer-to-peer abuse in the time the respondent had been working in the service. All of these services that had contacted Gardaí were mental health services (Table 23). Of the three that said they had contacted Gardaí, they emphasised how rare this was. They also stated it was only in the case of physical assault, sexual assault and life threatening or dangerous threats.

Table 23 Whether Gardaí were notified or not, by service type

Gardaí notified	**Count**
No	**22**
Day service	16
Mental Health Service	6
Yes	**3**
Mental Health Service	3
Total	**25**

Conclusion

Peer-to-peer abuse was reported as being rare in day services and mental health services. Verbal abuse was the most prevalent form of peer-to-peer abuse. The types of abuse recorded are solely based on the time frame in which the surveys were carried out and this does not mean other types of abuse, such as sexual abuse, may have occurred before the participant's time working there or after the survey was carried out. All respondents reported methods in place for the management of incidents of peer-to-peer abuse in their services. Most reported that their service used multiple methods of management when dealing with incidents of peer-to-peer abuse. Verbally addressing the situation was the most common single method used. The Gardaí had only been contacted about incidents of peer-to-peer abuse on very rare occasions in this survey - these were largely for physical abuse incidents.

When asked about what threshold is used for aggression and differentiation between different incidences, several individuals expressed the need for a tool or threshold indicator in regard to peer-to-peer abuse. Most said that they had no method for establishing a threshold for what constitutes abuse. A pattern of repetitive behaviour was the most common consideration taken when identifying if an incident constituted abuse. This is an important finding in that it speaks to the need to examine a situation

as a whole and not just an individual incident in determining if peer-to-peer abuse is happening. It is worth noting that no incidence of sexual abuse were reported in this survey. The consideration of whether a pattern of repetitive behaviour would likely be inappropriate in the context of sexual abuse. However, without reports of sexual abuse in the survey, we cannot comment on thresholds applied in such scenarios.

All services included in the survey documented incidents of peer abuse. The methods of documentation varied; the National Incident Management System (NIMS) was the most commonly used method of documentation. Respondents mentioned a variety of guidelines and protocols that they used in the services to inform their safeguarding practices, the HSE safeguarding policies were the most often referred to. There was a notable gap in service specific protocols in existence or use. Further confusion and lack of awareness on the topic was highlighted when some participants named policies/guidelines that do not exist, such as the "Safeguarding Ireland Policy" which was mentioned 4 times.

Behavioural and psychological elements of the service user's condition and environmental factors were the most common triggers reported. It was emphasized that is very dependent on who is in the service on a particular day and what the behavioural and psychological markers of their condition may be. This finding reinforces the known need for a person-centred approach to the prevention of incidents. It was generally thought (70%) that there were fewer incidents of peer-to-peer abuse when there was a higher staff to resident ratio.

Several limitations should be acknowledged in interpreting the findings of this survey. This survey size was small and was limited to services publicly listed, therefore, the full scope of services may not have been reached. Despite efforts to reach a representative sample, certain marginalized groups may have been underrepresented in the survey. This may limit the applicability of the findings to these populations and potentially overlook their unique experiences of peer abuse within mental health and day services. However, there was a high level of consistency in responses and, as such, expanding the survey further is unlikely to have changed the overall findings. There was a no available threshold or tool available for time of frequency of peer-to-peer abuse, therefore a subjective model was used. Participants were assured of the anonymity and confidentiality of their responses. Confidentiality protocols were strictly adhered to throughout the process to protect the privacy of those participating. Despite this assurance, participants may have been hesitant to give fully honest answers due to concerns about the security of their personal information which may have influenced their willingness to disclose information. As with any self-reporting there is as risk of bias where participants may underreport or misrepresent their experiences due to desirability bias and discomfort in disclosing sensitive information regardless of the anonymity factor.

Section 5 Desktop Survey of safeguarding operational policies in Ireland

Introduction

Effective guidelines and operational policies are essential in preventing and managing incidents of abuse such as peer-to-peer abuse, ensuring service users are protected from harm. Although there are many guidelines and policies in use in services in Ireland, there is a lack of a comprehensive overview. As such it is difficult to identify gaps or good practice in use that can be replicated elsewhere. The aim of this section was to identify existing guidelines and policies in use in order to highlight current practices, identify gaps, and provide insights that can inform awareness-raising campaigns and development of best practices for safeguarding of vulnerable populations.

Methods

A desktop survey of organisations in Ireland was conducted in order to identify guidelines and operational policies in relation to peer-to-peer abuse and safeguarding in services. All registered day services, mental health services and designated centres (for older persons and for people with disability) were identified. A sample of services was extracted from the total available sample of services (1202 day services, 66 mental health services, 400 nursing homes, 1146 residential disability services), after excluding services that participated in the telephone survey (Section 4). Searches of websites were carried out individually and manually to identify safeguarding policies that are available publicly.

A descriptive summary of the existing guidelines and policies was compiled and a deductive content analysis was undertaken using an a priori designed data extraction table. Table headings in the data extraction table included:

- Type of service (for example, day service, nursing home, residential disability service)
- Service user profile
- Service size
- Service provider type (for example, independent, charity, HSE)
- Person responsible for reporting
- Organisation to which incident is reported
- Other organisations to which the incident is also reported (for example, An Garda Síochána, HSE National Safeguarding Office (Regional Adult Safeguarding and Protection Team)
- Internal reporting requirement
- Other reporting requirements
- Thresholds used

- Underlying principles
- Requirements related to training
- Date of publication of guidelines/policy or date of last update
- External policies acknowledged
- Format of available Safeguarding information

Results

The random sample of services included for analysis included 54 Mental health services, 150 day services, 75 residential disability services, and 75 nursing homes, total 354.

Many service websites did not include any information on safeguarding policies, procedures or guidelines on their websites. Seventy-nine (22%) of the 354 websites investigated contained detail. A summary of the findings was compiled (Table 24).

Table 24 Summary of safeguarding guidelines and policies as available on service websites

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Deaf/blind individuals	All employees to the Designated Officer	not available	Designated Officer writes a report	Liaising with HSE team where necessary	not available	Liberty, Respect and Dignity, Privacy, Freedom to Choose, opportunities to fulfil personal aspirations and realise potential in their daily lives, opportunity to live safely without fear of abuse in any form, respect for possessions	Adverse event an incident Management training	Adverse event and incident Management
Day Service	Intellectually impaired individuals	Confidential Recipient	not available	not available	not available	zero tolerance*	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and A collaborative approach.	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with complex needs	not available	not available	not available	not available	zero tolerance	not available	not available	HSE National Policy and Procedure for Safeguarding Vulnerable Person at Risk of Abuse (2014)
Day Service	Individuals with intellectual disability	All employees to the Designated Officer	not available	not available	not available	not available	not available	not available	Derived from HSE Safeguarding vulnerable persons at risk of abuse national policy and procedures incorporating services for elder abuse and for persons with a disability
Day Service	Intellectually impaired individuals	Confidential Recipient	not available	not available	not available	zero tolerance	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and A collaborative approach.	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with moderate severe and profound intellectual disabilities	All employees to the Designated Officer	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures' + additional information	Liaising with HSE team where necessary	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures' + additional information	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures' + additional information
Day Service	Intellectually impaired individuals	not available	not available	not available	not available	not available	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and A collaborative approach.	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures
Day Service	Intellectually impaired individuals	Confidential Recipient	not available	not available	not available	not available	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially;	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
							Empowerment of individuals; and a collaborative approach.		
Day Service	Individuals with neuro-physical disabilities	Centre safeguarding co coordinator	not available	internal alert form	not available	no tolerance	Human Rights, Person Centeredness, Advocacy, Confidentiality, Empowerment, Collaboration	not available	e Health Information and Quality Authority (HIQA) and the Mental Health Commission (MHC) National Standards for Adult Safeguarding 2019, the HSE Final Draft Adult Safeguarding Policy 2019, the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures 2014

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Intellectual disability/ autism	Designated Officer	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)
Day Service	not available	not available	not available	not available	not available	not available	not available	not available	Safeguarding Guidance for Charitable organisations working with vulnerable persons
Day Service	Individuals with brain injuries	not available	not available	not available	not available	not available	not available	not available	Safeguarding Ireland 'Adult Safeguarding Charter'
Day Service	Individuals with brain injuries	not available	not available	not available	not available	Safeguarding Ireland 'Adult Safeguarding Charter'	not available	not available	not available

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with intellectual disability	not available	not available	not available	not available	not available	not available	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures' and HIQA Standards 2013
Day Service	Individuals with mental health issues	Anyone - non specified	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	not available	not available	not available	Designated Officer writes a report	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	not available
Day Service	Individuals with intellectual disability	not available	not available	mandated person writes report	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE Child protection and welfare policy 2019, Children's First National Guidance for the protection and welfare of children 2017,

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
									Children First Act 2015
Day Service	Individuals with intellectual disability	not available	not available	not available	not available	not available	not available	not available	Children First Act 2017 and any other legislation referring to the protection and welfare of children
Day Service	Individuals with complex needs	Designated Officer	not available	Internal notification form. Report the concern to the Safeguarding and Protection Team (Vulnerable Persons) within three working days after he/she has been informed of the concern	not available	not available	not available	not available	HSE National Policy and Procedure for Safeguarding Vulnerable Person at Risk of Abuse (2014), Trust in Care Policy HSE 2005, SPC Complaints Policy, Dignity in Work HSE 2004, HSE Policy on Open Disclosures 2019

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Intellectually impaired individuals	Designated Officer	not available	not available	not available	zero tolerance	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and A collaborative approach.	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures
Day Service	Intellectual disability or autism	not available	not available	not available	not available	not available	not available	Children First Act 2017	Children First Act 2017
Day Service	Intellectual disability or autism	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with varying disabilities	Designated Officer	not available	not available	not available	not available	not available	not available	not available
Day Service	Individuals with complex needs	Designated Officer	not available	not available	not available	not available	not available	not available	National Policy and Procedure for Safeguarding Vulnerable Person at Risk of Abuse (2014), Trust in Care Policy HSE 2005, SPC Complaints Policy, Dignity in Work HSE 2004, HSE Policy on Open Disclosures 2019
Day Service	Intellectual disability or autism	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Sightless children	Designated Officer	not available	Designated Officer writes a report	not available	not available	not available	Children First Act 2017	Children First Act 2017
Day Service	Intellectual disability or autism	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)
Day Service	Intellectual disability or autism	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	not available	not available	not available	not available	not available	not available	not available	not available	Safeguarding Guidance for Charitable organisations working with vulnerable persons
Day Service	Intellectual disability and/or autism	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)
Day Service	Intellectually impaired individuals	Confidential Recipient	not available	not available	not available	not available	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures,

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
							A collaborative approach.		
Day Service	Intellectually impaired individuals	Confidential Recipient	not available	not available	not available	zero tolerance	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and A collaborative approach.	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures,
Day Service	Individuals with disability	not available	not available	not available	not available	No tolerance	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	not available	not available	not available	not available	not available	not available	not available	not available	Safeguarding Guidance for Charitable organisations working with vulnerable persons
Day Service	Individuals with disability	not available	not available	not available	not available	No tolerance	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	Individuals with disability	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	People with complex intellectual, physical and mental disabilities	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	not available
Day Service	Individuals with disability	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy,	not available	HSE 'Safeguarding vulnerable persons at risk

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
							confidentiality, empowerment, collaboration		of abuse national policy and procedures'
Day Service	People with complex intellectual, physical and mental disabilities	not available	not available	not available	not available	not available	not available	Induction training	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)
Day Service	Individuals with autism spectrum disorder	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
									Welfare of Children (2017)
Day Service	Individuals with varying disabilities	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	People with complex intellectual, physical and mental disabilities	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	not available

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with complex needs	Designated Officer	not available	not available	not available	zero tolerance	not available	not available	National Policy and Procedure for Safeguarding Vulnerable Person at Risk of Abuse (2014), Trust in Care Policy HSE 2005, SPC Complaints Policy, Dignity in Work HSE 2004, HSE Policy on Open Disclosures 2019
Day Service	Individuals with varying disabilities	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with complex needs	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	Individuals with autism spectrum disorder	not available	not available	not available	not available	not available	not available	Induction training regarding safeguarding, E learning	not available
Day Service	Individuals with complex needs	not available	not available	not available	not available	not available	not available	Induction training regarding safeguarding, E learning	not available
Day Service	Intellectually impaired individuals	Confidential Recipient	not available	not available	not available	zero tolerance	Respect for human rights; person-centred approach to care and services; Promotion of advocacy; Respect for confidentially; Empowerment of individuals; and A collaborative approach.	not available	Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals in rehabilitation	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)
Day Service	Individuals in rehabilitation	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	Individuals with intellectual disability	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
									Guidance for the Protection and Welfare of Children (2017)
Day Service	Individuals with intellectual disability	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	Individuals with intellectual disability	not available	not available	not available	not available	No tolerance	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	Staff Trained in risk management, HSE E learning courses	Child Safeguarding Statement developed in line with requirements under the Children First Act 2015, Children First: National Guidance for the Protection and Welfare of Children (2017)

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Day Service	Individuals with intellectual disability	not available	not available	not available	not available	not available	Human rights, person centeredness, culture, advocacy, confidentiality, empowerment, collaboration	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'
Day Service	Individuals with complex needs	Designated Officer	not available	Internal notification form, Report the concern to the Safeguarding and Protection Team (Vulnerable Persons) within three working days after he/she has been informed of the concern	not available	not available	not available	not available	HSE National Policy and Procedure for Safeguarding Vulnerable Person at Risk of Abuse (2014), Trust in Care Policy HSE 2005, SPC Complaints Policy, Dignity in Work HSE 2004, HSE Policy on Open Disclosures 2019
Day Service	Individuals with complex needs	Designated Officer, Confidential recipient	not available	not available	not available	No tolerance	not available	not available	HSE 'Safeguarding vulnerable persons at risk of abuse national policy and procedures'

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated centre for older persons (nursing homes)	Older Persons	not available	not available	not available	not available	not available	not available	Safeguarding of Vulnerable Adults training every 2 years, staff induction policy included	not available
Designated residential centre for people with disabilities	Individuals with varying levels of disability	Designated Officer	HIQA, the HSE and the Clinical Indemnity Scheme	Details of the incident reporting process are described in the Company Safety Statement.	not available	no tolerance	not available	Training department assess the training needs of staff including those relating to safeguarding. Training is provided where a need has been identified	Children First National Guidance, HSE policy 'Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures 2014
Designated residential centre for people with disabilities	Individuals with varying levels of disability	Designated Liaison Officer	not available	not available	not available	not available	not available	not available	Children First: National Guidance for the Protection and Welfare of Children, Children First Act 2015
Designated residential centre for people with disabilities	Individuals with varying levels of disability	not available	not available	not available	not available	not available	not available	not available	Children First Act 2015

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	People with a wide range of learning and associated disabilities	Manager/ Authorised Person	HSE	Senior Staff Communications Book, Resident's Daily Report Record, Notification to a Relevant Authority Form, Resident's Personal Plan	not available	not available	not available	Staff should receive training on the different forms of abuse and be equipped to recognise the signs of abuse that may have taken place	HSE Safeguarding Vulnerable Persons at Risk of Abuse National, HSE Trust In Care
Designated residential centre for people with disabilities	People with a wide range of learning and associated disabilities	Manager/ Authorised Person	HSE	Senior Staff Communications Book, Resident's Daily Report Record, Notification to a Relevant Authority Form, Residents Personal Plan	not available	not available	not available	Staff should receive training on the different forms of abuse and be equipped to recognise the signs of abuse that may have taken place	HSE Safeguarding Vulnerable Persons at Risk of Abuse National, HSE Trust In Care

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	Adults with mild to moderate intellectual disability	Designated Officer	not available	Within 3 working days. The report will need to include: When the disclosure was made, or when you were told about/witnessed this incident/s, Who was involved and any other witnesses, including service user and other staff, Exactly what happened or what you were told, using the person's own words, keeping it factual and not interpreting what you saw or were told, Any other relevant information.	Safeguarding vulnerable persons at risk of abuse national policy and procedures preliminary screening form (PSF1), preliminary screening outcome sheet (PSF2), referral form for community-based referrals safeguarding vulnerable persons at risk	not available	not available	not available	Centre Mission Statement and Statement of Purpose and the HSE document Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures.

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	Individuals with varying levels of disability	Designated Officer	HIQA, the HSE and the Clinical Indemnity Scheme	Details of the incident reporting process are described in the Company Safety Statement.	not available	no tolerance	not available	Training department assess the training needs of staff including those relating to safeguarding. Training is provided where a need has been identified	Children First National Guidance, HSE policy 'Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures 2014
Designated residential centre for people with disabilities	Individuals with varying levels of disability	Designated Officer, Mandated persons	not available	not available	not available	not available	not available	Introduction to children first e learning course, Staff training and supervision, safeguarding vulnerable adults training	https://www.hse.ie/eng/about/Who/socialcare/safeguardingvulnerableadults/informationforfamiliesonsafeguardingpolicy.pdf http://safeguardingcommittee.ie/index.php/2017/10/16/lid-must-be-lifted-on-financial-abuse-of-vulnerable-adults/ HSE Child protection and welfare policy 2017 Children First Act 2015

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	Individuals with varying levels of disability	Designated Officer, Mandated persons	not available	not available	not available	not available	not available	Introduction to children first e learning course, Staff training and supervision, safeguarding vulnerable adults training	https://www.hse.ie/eng/about/Who/socialcare/safeguardingvulnerableadults/informationforfamiliesonsafeguardingpolicy.pdf http://safeguardingcommittee.ie/index.php/2017/10/16/lid-must-be-lifted-on-financial-abuse-of-vulnerable-adults/ HSE Child protection and welfare policy 2017 Children First Act 2015

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	Individuals with varying levels of disability	Designated Officer, Mandated persons	not available	not available	not available	not available	not available	Introduction to children first e learning course, Staff training and supervision, safeguarding vulnerable adults training	https://www.hse.ie/eng/about/Who/socialcare/safeguardingvulnerableadults/informationforfamiliesonsafeguardingpolicy.pdf http://safeguardingcommittee.ie/index.php/2017/10/16/lid-must-be-lifted-on-financial-abuse-of-vulnerable-adults/ HSE Child protection and welfare policy 2017 Children First Act 2015

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	Individuals with varying levels of disability	not available	not available	not available	not available	not available	Compassion, Collaboration and Excellence. The safety, welfare and development of children and young people is a core objective and key priority for the Service. Every member of staff has a responsibility, and duty of care, to ensure that every child / young person availing of our service is safe and protected from harm (physical/emotional /sexual abuse/neglect). Policies and procedures are in place to promote safe environments for all users in order to mitigate the potential for risk to arise, and to manage it safely, if it arises.	Staff induction and mandatory training on procedures.	Children First Act 2015, the Children First: National Guidance for the Protection and Welfare of Children (2017), and Tulsa's Child Safeguarding: A Guide for Policy, Procedure and Practice

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Designated residential centre for people with disabilities	Services and supports to children 0 – 18 years with a mild, moderate and severe to profound intellectual disability and children and adolescents with mental health needs	All Staff	not available	not available	not available	not available	not available	Mandatory for all staff to complete Children First E-Learning training and keep their certificates in date (renewable every 3 years)	Children First Act 2015 and Children First National Guidance 2017
Mental Health	Individuals with mental health issues/ Psychiatric issues	not available	MHC	Q Pulse System	not available	not available	not available	not available	not available
Mental Health	Mental healthcare to individuals aged between 12-17 years	Designated Liaison Person	not available	not available	not available	not available	not available	not available	The Children First Act 2015, Children First: National Guidelines for the Protection and Welfare of Children 2017, 'varieties of protocol and policies'

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Mental Health	Young people aged from 14 years up to 18 years old who are experiencing mental health difficulties	Designated Liaison Person and Mandated persons	not available	not available	not available	not available	not available	Child Protection and Child Protection Training Policy. Child Safeguarding Training is mandatory for all staff and volunteers. All staff and volunteers complete the HSE e-Learning Module "An Introduction to Children First". All Mandated Persons participate in an in-person Mandated Persons Training module every 3 years. Staff who work directly with children receive training on Children First which meets standards set out in "Best	The Children First Act 2015 and Children First: National Guidance for the Protection and Welfare of Children 2017, TUSLA's Child Safeguarding: A Guide for Policy, Procedure and Practice

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
								Practice Principles for Organisations in Developing Children First Training Programmes", TUSLA, 2017	

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Mental Health	Individuals with substance misuse, psychotic disorders, eating disorders, psychiatry of later life and adolescent mental health.	Designated Liaison Person and Mandated persons	not available	not available	not available	not available	not available	Child Protection and Child Protection Training Policy Child Safeguarding Training is mandatory for all staff and volunteers. All staff and volunteers complete the HSE e-Learning Module "An Introduction to Children First". All Mandated Persons participate in an in-person Mandated Persons Training module every 3 years. Staff who work directly with children receive training on Children First which meets standards set out in "Best	The Children First Act 2015 and Children First: National Guidance for the Protection and Welfare of Children 2017, TUSLA's Child Safeguarding: A Guide for Policy, Procedure and Practice

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
								Practice Principles for Organisations in Developing Children First Training Programmes", TUSLA, 2018	

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Mental Health	Mental healthcare to individuals aged between 12-17 years	Designated Liaison Person	not available	not available	not available	not available	not available	not available	Children First Act 2015, Children First: National Guidelines for the Protection and Welfare of Children 2017, 'varieties of protocol and policies'
Mental Health	Mental healthcare to individuals aged between 12-17 years	Designated Liaison Person	not available	not available	not available	not available	not available	not available	The Children First Act 2015, Children First: National Guidelines for the Protection and Welfare of Children 2017, 'varieties of protocol and policies'
Mental Health	Individuals with mental health issues	not available	not available	not available	not available	not available	not available	not available	not available
Mental Health	General adult psychiatry, psychiatry of later life, and rehabilitation and recovery	not available	not available	not available	not available	not available	not available	HSE e learning Children First Module	The Children First Act 2015

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Mental Health	Individuals with mental health issues	not available	not available	not available	not available	not available	The safety and welfare of children is everyone's responsibility. The best interests of the child should be paramount. Children have a right to be heard, listened to and to be taken seriously. Taking account of their age and understanding, they should be consulted and involved in all matters and decisions that may affect their lives, all children must be treated equally, Child protection is a multi-agency, multidisciplinary activity. Agencies and professionals must work together in the best interests of children.	HSE Children First training	Child Safeguarding Statement has been developed in line with requirements under the Children First Act 2015, Children First National Guidance for the Protection and Welfare of Children (2017), HSE Guidance on Developing a Child Safeguarding Statement and Guidance issued by Tusla – Child and Family Agency. Professional Registration for Health professionals 2. Hospital Visiting Policy 3. HSE National Open Disclosure Policy

Type of Service	Service User Profile	Person Responsible for reporting	Main organisation reported to	Internal reporting requirements	Other reporting requirements	Thresholds used for reporting	Underlying principles	Requirements related to training	External policies acknowledged
Mental Health	Individuals with mental health issues	not available	not available	not available	not available	not available	not available	HSE e learning Children First Module	The Children First Act 2015 and Children First: National Guidance for the Protection and Welfare of Children 2017

*zero tolerance: The requirement that there should be no acceptance of abuse or neglect of any kind”

Of the services that made their policies available online, there are many comprehensive safeguarding policies emphasising the safety and dignity of service users. Regular safeguarding training and updated practice is a common requirement across services ensuring staff are capable to prevent, address and manage incidents of abuse. Defined internal and external reporting protocols are in place in most services with published policies. There are however, gaps in some areas. There are some inconsistencies in the comprehensive specificity of policies across different services. This can be seen most clearly when contrasting public and private organisations. In regard to peer-to-peer abuse, a lack of specific training was identified. Differences in reporting thresholds and procedures between services, or lack thereof (as was common), is likely to lead to inconsistencies in how incidents are managed, documented and reported across the country. Not all services have a clear schedule for regularly reviewing and updating their policies. The lack of safeguarding policies for adults in comparison to child safeguarding statements was also highlighted in this search. Whilst there seems to be an emphasis on accessible child safeguarding policies and statements there is a lack of information readily available on safeguarding adults at risk.

Conclusion

The desktop survey shows that while many organisations in Ireland have established guidelines and operational policies on safeguarding, there are variations in the detail and implementation of these policies. There were also many organisations that did not have any published documents relating to safeguarding and as such are not captured in this desktop survey. Training programmes and clear reporting mechanisms are strengths of the available policies, ensuring staff are equipped to manage incidents effectively. However, the survey also highlights gaps, including inconsistencies in policy detail, variable training quality, and differences in reporting thresholds and procedures. These gaps underscore the need for standardised best practice and regular updates to policies. The lack of online readily available information specifically on reporting practices in services was also highlighted.

These findings should be interpreted in the context that they are based solely on available polices. Other policies and guidance may be in place in services but not published. That said, the inconsistencies and gaps identified from the available policies highlight the need for awareness raising campaigns, targeted training on peer-to-peer abuse, a definition and clear thresholds to ensure safe and supportive environments for all individuals in residential and day services in Ireland.

Section 6 Delphi study on definitions and thresholds of peer-to-peer abuse

Introduction

Although there are descriptors available in Ireland of what constitutes peer-to-peer abuse, for example from the HSE, "An abusive interaction involving one service user towards another or towards a group of service users within a care setting",[10] there is a lack of a clear definition and thresholds to inform the difference between peer aggression and peer-to-peer abuse. Both definitions and thresholds are important in informing prevention and management strategies to ensure service users' rights to be safe and live lives free from harm.

Methods

To inform a proposal for a definition and thresholds for peer-to-peer abuse, a Delphi study[11] was conducted with a targeted group of stakeholders with expertise in the area.

Participants for the Delphi study were identified through a process of stakeholder mapping and consultation with Safeguarding Ireland and HIQA representatives. Prospective stakeholder organisations (n=12), both from Ireland and abroad, were sent an email outlining the nature of the study and seeking a nominated person to participate.

Eight responses agreeing to participate were received.

The Delphi study proceeded through two rounds. Each participant received a survey to complete (Appendix 3) and the responses were analysed for agreement. The survey circulated in the subsequent round was informed by the results of the first round. Consensus was considered to be reached where 85% or more of participants agreed with a statement.

Participants were asked first about the definition, as was identified from the literature (Section 2). There were three elements to the definition, the term for the services, the description of the interaction and the description of the outcome. Participants were then asked about considerations for when an interaction crosses the threshold from aggression to abuse between peers in a service.

[10] https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/peerabuse.pdf

[11] A Delphi study is a survey that is done in rounds until consensus is reached among participants. A statement is proposed and participants either agree or disagree with it. Where a participant disagrees, they are offered the opportunity to suggest changes. The statement is then updates based on the suggested changes and the survey is re-run with the new statement. The study ends when consensus is reached on the statement.

Results

When asked about the use of the term 'service users' within the definition, consensus was reached on the use of the term. Respondents who disagreed or were unsure on their agreement made suggestions to change the term to 'people we support', 'citizen' and 'people being supported or those living in community supported settings'.

When asked about the description of the interaction 'Negative, aggressive and intrusive verbal, physical, sexual, and material interactions', in the first round consensus was not reached and a number of suggested changes were returned. Those who did not agree (30%) made suggestions to alter the descriptions or thought the description did not cover all incidents. The suggested alterations included a change of the word 'negative' to 'improper, offensive, harmful, unwanted or unconsented'. The other recommendation was to change the definition to 'Behaviours of concern towards peers, including, physical, verbal or emotional'. Following the second round, consensus was reached on "Offensive, aggressive and intrusive verbal, physical, sexual, and material interactions"

When asked about the description of the outcome "would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient", consensus was reached on the first round. Those who disagreed only slightly disagreed and suggested that emotional and perhaps trauma should be included in the description and that socially acceptable and long-term trauma be included also.

In informing a threshold, participants were asked if they agreed that for an interaction to cross the threshold from aggression to abuse there needs to be intention and capacity on the part of the exhibitor/perpetrator. These were considerations of what constitutes abuse as identified in the literature (Section 2). There was agreement that this should be a consideration. Participants were then asked what other considerations should be included when setting thresholds. Suggestions included:

- The perception of the situation by the person in receipt of the aggression and/or abuse
- The behavioural history of the exhibitor/perpetrator
- The external factors - the environment, the measures taken or not taken to prevent aggression and impact on others, the supports that have been provided to exhibitor/perpetrator and their success and implementation.

It was also noted that regardless of intention or capacity of the exhibitor/perpetrator, the recipient suffers abuse and should be safeguarded.

Conclusion

Consensus on a definition was reached, this was:

> "Offensive, aggressive and intrusive verbal, physical, sexual, and material interactions between service users that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient".

In terms of a proposal for thresholds, no definitive threshold was arrived at but rather a list of considerations that should be taken into account when determining if an incident or situation constitutes abuse. These were- the need for intention and capacity to understand their actions on the part of the exhibitor/perpetrator; the perception of the recipient/victim; the behavioural history of the exhibitor/perpetrator; and environmental factors such as the supports that have been provided to the exhibitor/perpetrator and their implementation and success.

An important consideration was also highlighted which was that regardless as to whether the incident constitutes abuse by the exhibitor/perpetrator, the recipient/victim suffers abuse and should be safeguarded.

Section 7 Conclusions and Recommendations

This report consists of the findings of a programme of research aimed at informing definitions and thresholds, improving understanding of current reporting practices and available safeguarding policies and improving understanding of frequency and nature of peer-to-peer aggression and abuse in care settings in Ireland. This research is limited to services that service users either live together or spend prolonged periods of time together. It does not cover services such as supported living where the service user lives alone, as the focus is on peer-to-peer interactions and not wider safeguarding concerns. Although this research includes a large proportion of service types in Ireland it is not comprehensive for all service types, for example, homeless hostels, international protection accommodation services and community residential mental health services are not included due to lack of available data from these service types.

Recent literature and opinion on the topic of peer-to-peer abuse has sought to define and categorise various types of interactions between residents of long-term care settings. Peer-to-peer or resident-to-resident aggression, is a proposed term to capture the nature of the phenomenon. The use of the term 'aggression' as opposed to abuse removes any assumption that the exhibitor/perpetrator wilfully intended to cause harm whilst also not minimising the impact on the recipient/victim. Moreover, use of "aggression" allows for the consideration of the perpetrator as someone who can suffer harm due to an unmet need, an unsuitable placement or as a consequence of a cognitive impairment and thereby lacking capacity to understand the impact of their actions. Notwithstanding the above, there are circumstances where peer-to-peer or resident-to-resident aggression can indeed constitute abuse. Identifying a threshold at which an incident transgresses from 'aggression' to 'abuse' is challenging. It requires safeguarding practitioners to establish that the perpetrator did something intentionally, had capacity to understand their actions, whilst also proving that the incident occurred and met a definition for abuse.

Although there were reports of peer-to-peer abuse from all services types, it appears that most of the interactions of peer-to-peer abuse were low-level disputes. We used notification to An Garda Síochána as a proxy for seriousness of an incident. Notification to Gardaí was rare across all service types. Evidence from the telephone survey and the analysis of statutory notifications suggests that notification to Gardaí was rare due to the incidences not being considered serious enough to warrant notification. It was also noted that the most common management of an incident approach was to verbally address the situation, which is suggestive of consideration of the incidents as low-level disputes. Without thresholds for what constitutes abuse in place, it is difficult to ascertain whether this low level of serious incidents is due to low levels of peer-to-peer abuse or low levels of recognition of such.

The most common type of peer-to-peer aggression or abuse differed by services types. In disability services, it was psychological, followed by physical. In services for older persons, it was physical. In day services and mental health services it was verbal abuse.

The environment was associated with the occurrence of peer-to-peer aggression and abuse. In the quantitative analysis, a higher incidence was observed, in services with more staff, in services with higher staff to resident ratios and in services with higher bed numbers. However, in the qualitative survey, respondents felt that when there were more staff in place there was a lower incidence of peer-to-peer aggression and abuse. These somewhat conflicting finding is likely explained by the individual needs of the residents in these different types of services. Some environmental triggers mentioned included, loud noises and shouting. Behavioural and psychological elements of the service user's condition were commonly reported as triggers. This finding reinforces the known need for a person-centred approach to the prevention of incidents.

Despite good practice to relevant agencies in relation to reporting of the occurrence of an incident, where an occurrence was recognised, there were large discrepancies in the quality of the information recorded about incidents and inconsistencies in both how and what is being recorded. There also appears to be an element of over reporting resulting from a difficulty in determining when service user interactions constitute abuse and where individual events would not constitute abuse but a pattern of behaviour over time would. There was an expressed need by participants in this research for a definition and thresholds for peer-to-peer aggression and abuse.

Many organisations in Ireland have established guidelines and policies on safeguarding. However, there were variations in the detail of these policies at service level. Training programmes and clear reporting mechanisms are strengths of the available policies. Weaknesses included inconsistencies in policy detail, variable training quality, and differences in reporting thresholds and procedures. Specific training on peer-to-peer aggression and abuse was not evident.

Consensus on a definition was reached, this was:

"Offensive, aggressive and intrusive verbal, physical, sexual, and material interactions between service users that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient".

In terms of a proposal for thresholds, no definitive threshold was arrived at but rather a list of considerations that should be taken into account when determining if an incident or situation constitutes abuse. These were, the need for intention and capacity to understand their actions, on the part of the exhibitor/perpetrator, the perception of the recipient/victim, the behavioural history of the exhibitor/perpetrator and environmental factors such as the supports that have been provided to the exhibitor/perpetrator and their implementation and success.

An important consideration was also highlighted which was that regardless as to whether the incident constitutes abuse by the exhibitor/perpetrator, the recipient/victim suffers abuse and should be safeguarded. A person may be exhibiting behaviour that does not meet the threshold for abuse and as such should be supported to manage their behaviour rather than being penalised. However, for a person on the receiving end of the same behaviour, this may constitute abuse and they should be supported and safeguarded appropriately.

Five recommendations are drawn from this research.

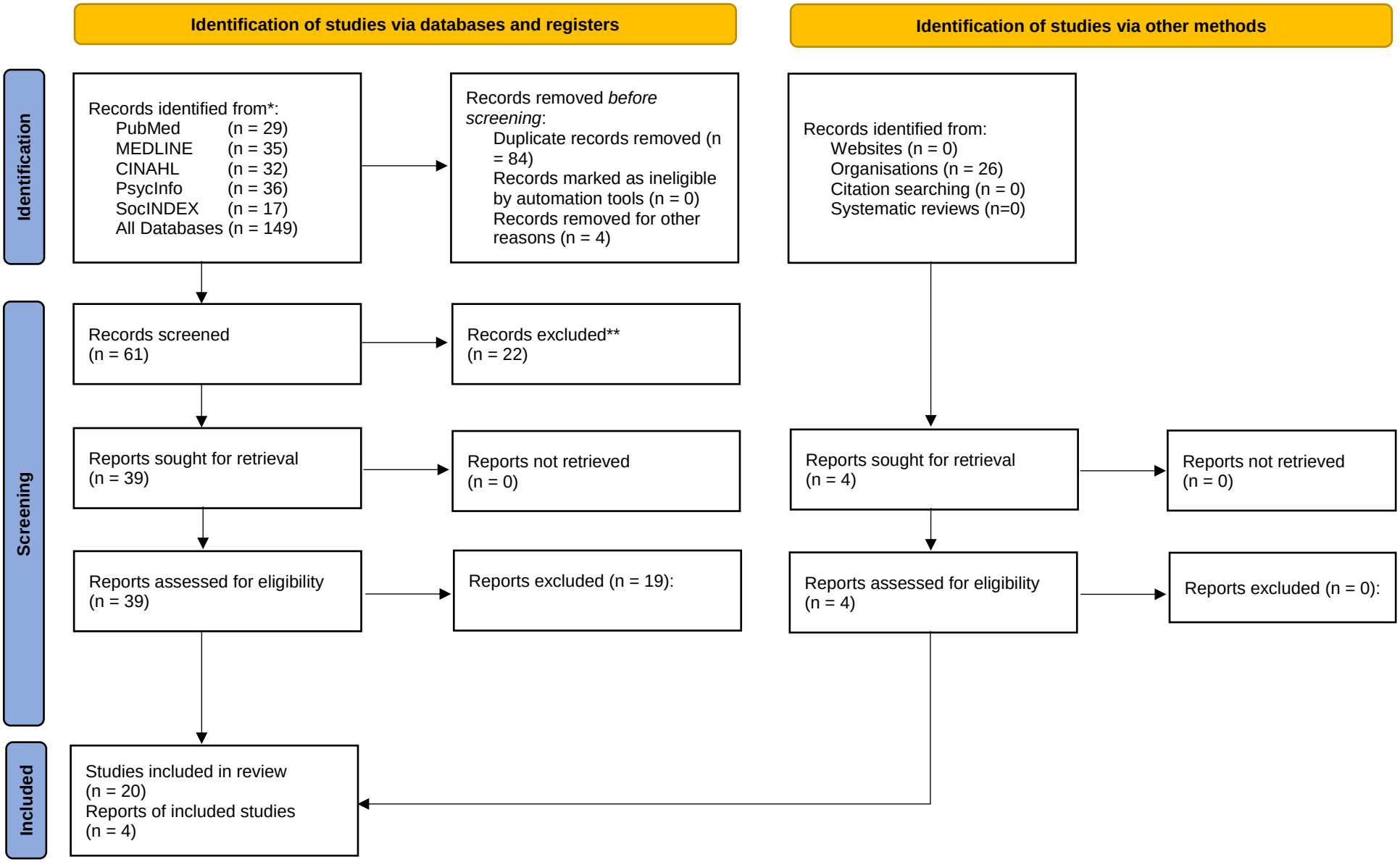
1. Move to the use of two terms, "peer-to-peer aggression" and "peer-to-peer abuse". This would both capture the common low-level incidents that routinely occur in services and the more serious abuse incidents but also allow for differentiation using thresholds (Recommendation 3), enabling appropriate responses to be taken and support given to service users.
2. Introduce a definition for peer-to-peer abuse based on the following: Offensive, aggressive and intrusive verbal, physical, sexual, and material interactions between service users that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient,
3. Introduce a list of considerations for determining if an incident or situation constitutes abuse that includes the following: the need for intention and capacity to understand their actions, on the part of the exhibitor/perpetrator, the perception of the recipient, the behavioural history of the exhibitor/perpetrator and environmental factors such as the supports that have been provided to the exhibitor/perpetrator and their implementation and success. Any definitions and thresholds agreed on should be used in the development of safeguarding policies.
4. Develop specific training on peer-to-peer aggression and abuse. This should include the need for a person-centred approach to the prevention of peer-to-peer abuse incidents and the need to separate the concept of abuse by the exhibitor/perpetrator from abuse of the recipient.
5. Strengthen reporting requirements to support consistency in information collection and ensure inclusion of detail on severity of incidents, including

introducing a system that supports data aggregation and analysis of frequency and severity of incidents.

This study was not able to adequately evaluate certain phenomenon relating to peer-to-peer aggression and abuse. Further research into the areas of triggers, demographics of service users as gender, age or ethnicity, resources of services, and research within other service types such as in homeless hostels, international protection accommodation services and community residential mental health services, is warranted. In order to get a more accurate picture on the applicability of this topic to non-listed or publicly accessible services a further study similar to this one could be recommended to their regulatory bodies.

Appendices

Appendix 1 PRISMA 2020 flow diagram



Appendix 2 Telephone Survey Questionnaire

1. How often have you witnessed or experienced resident-to-resident aggression/abuse in the facility? (Never, Rarely, Sometimes, Often, Constant)
2. How many times/incidences per day/week would there be resident-to-resident aggression/abuse? (Numerical)
3. In what ways have resident-to-resident aggression/abuse occurred? (An act of omission, Discriminatory, Financial or Material, Neglect, Physical, Psychological, Sexual, Violation of integrity, Institutional Violence, Other please specify)
4. What (if anything) triggers incidents of resident-to-resident aggression/abuse in your facility? Such as but not exclusively; Environmental factors (noise, overcrowding etc., cognitive impairment, physical discomfort, communication difficulties, invasion of space.
5. How are incidents of resident-to-resident aggression/abuse typically managed in your work place? (Verbally addressing the situation, Separating individuals, Documenting the incident, involving higher management, other please specify)
6. Are incidents documented? (yes/no)
7. If so how are they documented?
8. Who is notified?
9. Are the Gardaí ever notified of resident-to-resident abuse events? (yes/no)
10. If yes how often?
11. Do you have a threshold/marker/indicator for when aggression turns to abuse?
12. Is there any protocol/guidance you could share with me on this?
13. What is the staff to resident/service user ratio in your facility? (Numerical)
14. Do you feel the staff to resident/service user ratio effects the amount of resident-to-resident incidents? (yes/no)
15. How many service users/residents typically present in your facility? (Numerical)

Appendix 3 Peer-to-peer Abuse and Aggression Definition and Thresholds Survey

Thank you for participating.

Please read before completing the survey. We would like to remind you that the aim of this project is to reach a consensus on determining and defining peer-to-peer aggression and abuse for adults at risk. This new definition will be used to inform legislative change, guidance, regulatory practice and awareness improvement campaigns.

This survey should take no more than 10 minutes. Your replies will remain anonymous with only the moderating team having access to your identifying information. Please answer all of the questions.

Your Name

Your Organisation

Definition of Peer-to-peer Aggression or Abuse

We completed a review of published literature on the topic of peer-to-peer aggression and abuse. The most commonly used definition is as follows:

"Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between service users that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient"

Question 1

Do you agree with the use of the term "service users" within the definition?

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

If you disagree please suggest changes

Question 2

Do you agree with the description of the interaction "Negative, aggressive and intrusive verbal, physical, sexual, and material interactions"?

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

If you disagree please suggest changes

Question 3

Do you agree with the description of the outcome "would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient"?

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

If you disagree please suggest changes

Thresholds of Peer-to-peer Aggression or Abuse

There were no articles in the literature review that specifically referred to thresholds for when peer-to-peer aggression becomes abuse. What was identified from the literature is the consideration of the capacity of the exhibitor/perpetrator to understand their actions at the time of the incident.

Question 4

Do you agree that for an interaction to cross the threshold from aggression to abuse there needs to be intention on the part of the exhibitor/perpetrator?

- Strongly Agree

- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

If you disagree please suggest changes

Question 5

Do you agree that for an interaction to cross the threshold from aggression to abuse there needs to be capacity to understand on the part of the exhibitor/perpetrator?

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

Are there any other considerations you would suggest for inclusion in a threshold for what constitutes abuse between peers?

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