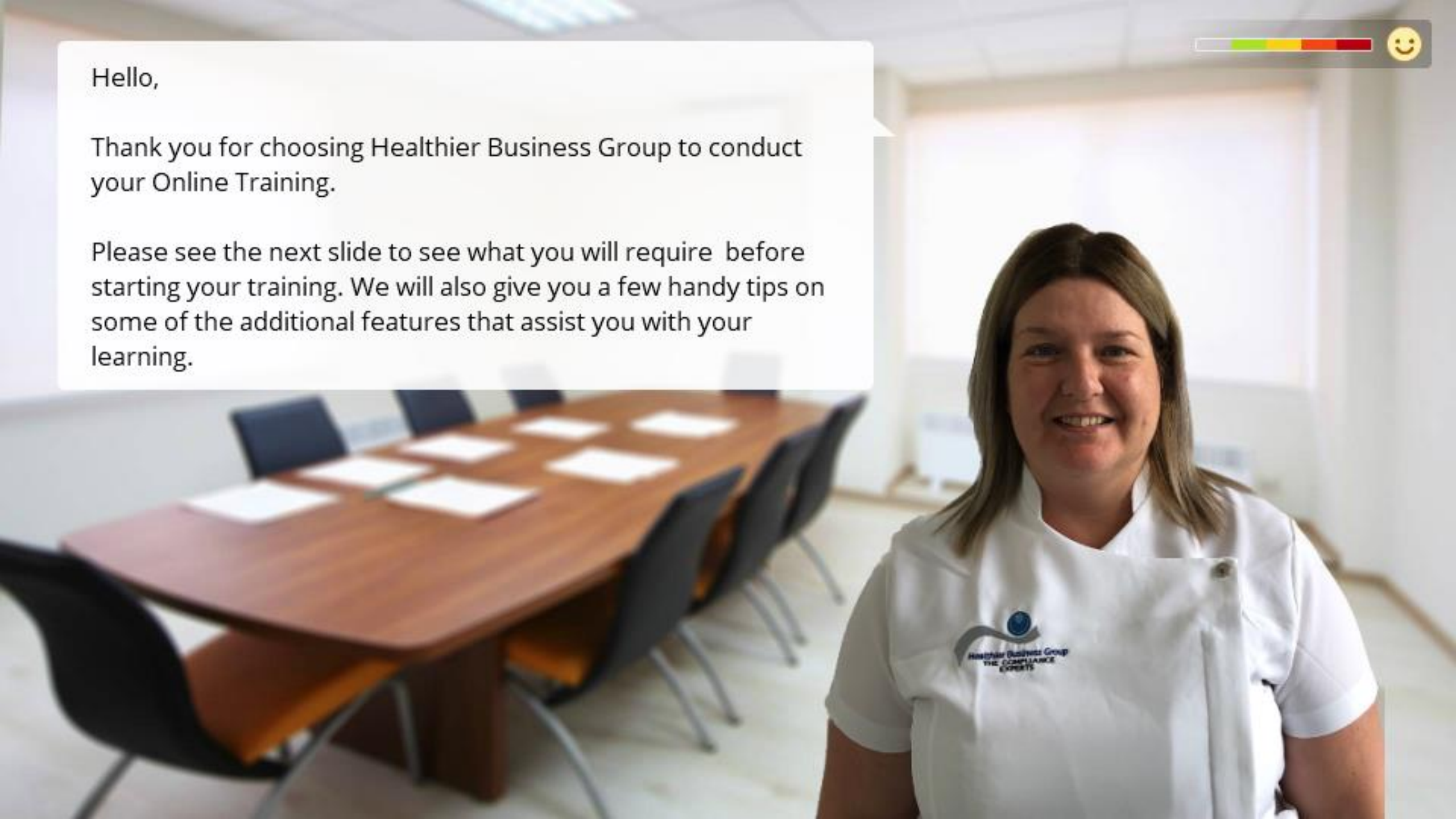
Safeguarding Vulnerable Adults (Level 3)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This course is intended for those staff working within health and social care or integrated and who have a designated responsibility to manage as well as investigate adult protection concerns. This includes Social Workers, community psychiatric nurses, medical doctors and general practitioners. It also applies to designated care coordinator managers of staff who may refer; those who chair investigations; are responsible for operational management of safeguarding issues or strategic management and those who have the responsibility to manage as well as investigate adult protection concerns teams.

AIMS AND OBJECTIVES

Health and social care professionals working with adults are required to complete the Safeguarding Adults course, often referred to as SOVA. Those undertaking this training should have completed Safeguarding of Vulnerable Adults (SOVA) Level 1 before commencing this module that will cover Levels 2 and 3.

On completion of this course you should be able to:

- Understand the term safeguarding adults and how to support people to keep them safe.
- Be able to respond to safeguarding alerts/referrals
- Know what legislation is relevant to undertaking safeguarding activity
- Achieve good outcomes in preventing and effectively responding to harm, neglect and abuse
- Understand how to apply the principles of the Mental Capacity Act 2005
- Understand how to apply issues regarding choice
- Understand how to involve adults at risk and those alleged to be responsible in investigations
- Understand the purpose of an investigation and good practice in report writing
- Understand how decisions should be made following case conferences
- Plan an adult protection investigation
- Providing strong leadership to make safeguarding integral to care
- Use systems & standards to prevent and respond to neglect and abuse
- Assure compliance with Essential Standards of Quality and Safety
- Use strategic partnerships including the local Safeguarding Adults Board

This course draws upon legislation and official guidance references, including:

- Health and Social Care Act 2013
- Safeguarding Vulnerable Groups Act 2006
- Care Act 2014 – (official guidance published by the Department of Health and the Home Office)
- Local Authority Social Services Act 1970
- Human Rights Act 1998
- Data Protection Act 1998
- Public Interest Disclosure Act 1998
- The Mental Capacity Act 2005
- The Equality Act 2010

INTRODUCTION

The safeguarding of vulnerable adults (SOVA) at risk continues to be one of the most important and challenging tasks facing society. Awareness of adult abuse has received growing attention from the Government, the public, the media and voluntary/ statutory agencies over recent years and this is reflected in the increasing number of referrals both nationally and locally. This module sets out how all individuals and agencies with the responsibility maintain and uphold the wellbeing and safeguarding of adults and how they should work together to facilitate and implement appropriate action to protect them from abuse, exploitation and/or mistreatment.

Care workers have a responsibility to contribute to the protection of individuals from abuse. To ensure effective and high standards of professional practice, it is essential for workers in care settings to know how society handles abuse, how to recognise it and what to do about it.

WHAT IS SAFEGUARDING?

Safeguarding is about protecting certain people who may be in vulnerable circumstances. These people may be at risk of abuse or neglect due to the actions (or lack of action) of another person. In these cases, it is vital that public services work together to identify people at risk, and put steps in place to help prevent abuse or neglect. It is an important shared priority of many public services and a key responsibility of local authorities (GOV UK, 2015).

Following a report published by the Law Commission on adult care law in 2011, recommendations were made for a single, clear, modern statute and code of practice, which in their view would pave the way for a coherent social care system. It included recommendations in relation to safeguarding adults at risk of abuse. With regards to the latter recommendations on safeguarding, the Government gave its response in July 2012. The Government committed to include in any subsequent Bill a new statutory framework for adult safeguarding;

- A clarification of the roles and responsibilities of local authorities and other organisations
- To legislate to create Safeguarding Adult Boards in every local authority area

The Government has since introduced a draft Care and Support Bill which includes these provisions and this is currently being examined by a Joint Committee before being presented to Parliament.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216844/dh_134740.pdf)

WHAT IS ABUSE OR NEGLECT?

The Mental Capacity Act covers and empowers children aged 16 and 17. Once 18, the young person is an adult.

An adult at risk of harm is defined in the Care Act 2014 as:
"Someone who has needs for care and support, and is experiencing, or at risk of, abuse or neglect and is unable to protect themselves"

Abuse can lead to a violation of someone's human and civil rights by another person or persons. It can be physical, financial, verbal or psychological. It can be the result of an act or a failure to act. It can happen when an adult at risk is persuaded into a financial or sexual exchange they have not consented to, or can't consent to due to incapacity. Abuse can occur in any relationship and may result in significant harm or exploitation. In essence, it is the misuse of power and being in control of an individual.

The ages of reported abuse are, in percentage terms:

- 40% 18-64-year olds
- 12% 65-74-year olds
- 22% 75-84-year olds
- 26% 85 or above

The types of reported abuse are, in percentage terms:

- 29% physical abuse
- 26% neglect
- 19% financial abuse
- 16% psychological abuse
- 10% sexual, institutional or discriminatory abuse

Areas of abuse is carried out:

- 40% victim's own home
- 36% residential care setting
- 24% other location

People are abused by, in percentage terms:

- 28% social care staff
- 22% family members
- 13% unknown
- 7% other
- 6% neighbour/friend
- 5% healthcare worker
- 3% other professional
- 2% stranger

https://catalogue.ic.nhs.uk/publications/social-care/vulnerable-adults/abus-vunr-adul-eng-11-12-final/abus-vunr-adul-eng-11-12-fin-rep.pdf

ABUSE CAN FALL INTO ANY OF THE FOLLOWING CATEGORIES:

PHYSICAL	This includes assault, hitting, slapping, pushing, giving the wrong (or no) medication, restraining someone or only letting them do certain things at certain times.
DOMESTIC	This includes psychological, physical, sexual, financial or emotional abuse. It also covers so-called 'honour' based violence.
SEXUAL	This includes rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, taking sexual photographs, making someone look at pornography or watch sexual acts, sexual assault or sexual acts the adult didn't consent to or was pressured into consenting.
PSYCHOLOGICAL	This includes emotional abuse, threats of harm or abandonment, depriving someone of contact with someone else, humiliation, blaming, controlling, intimidation, putting pressure on someone to do something, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or support networks.
MODERN SLAVERY	This covers slavery (including domestic slavery), human trafficking and forced labour. Traffickers and slave masters use whatever they can to pressurise, deceive and force individuals into a life of abuse and inhumane treatment.
DISCRIMINATORY	This includes types of harassment or insults because of someone's race, gender or gender identity, age, disability, sexual orientation or religion.
ORGANISATIONAL	This includes neglect and poor care in an institution or care setting such as a hospital or care home, or if an organisation provides care in someone's home. The abuse can be a one-off incident or repeated, on-going ill treatment. The abuse can be through neglect or poor professional practice, which might be because of structure, policies, processes and practices within an organisation.
NEGLECT AND ACTS OF OMISSION	This includes ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, or not giving someone what they need to help them live, such as medication, enough nutrition and heating.
SELF-NEGLECT	This covers a wide range of behaviour that shows that someone isn't caring for their own personal hygiene, health or surroundings. It includes behaviour such as hoarding.

CARE ACT 2014

The Care Act 2014 is statutory guidance that replaced the No Secrets Act and came into force on 1st April 2015. The Care Act recognises that local authorities cannot safeguard individuals on their own and can only be achieved by working alongside other associations including the police, NHS and other key organisations as well as relying on the awareness of the wider public. Fears of sharing information must not stand in the way of protecting adults at risk of abuse or neglect.

The Act includes new duties for Safeguarding Adults Boards (SAB) to work more closely together and share information. The statutory guidance also introduces Designated Adult Safeguarding Managers (DASMs) in organisations concerned with adult safeguarding. **Safeguarding adults at risk of harm**: *A legal guide for practitioners Social Care Institute for Excellence.*

This guide outlines the legal basis for the safeguarding of vulnerable adults at risk of harm. This is intended to give practitioners useful legal pointers. Further advice should be sought where necessary as the law is constantly changing and each case is different and should be taken on its merit.

The Government is committed to improving the quality of health and social care, developing accountability to patients and strengthening the choice and control they have over their care. It has therefore agreed SIX key principles for safeguarding adults that can provide a foundation for achieving good outcomes for patients.

THE SIX PRINCIPLES OF SAFEGUARDING:

Principle 1 – Empowerment - Presumption of person led decisions and consent

Adults should be in control of their care and where their consent is needed for any decisions and plan of actions designed to protect them. There must be clear justification when action is taken without consent such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

Principle 2 – Protection - Support and representation for those in greatest need

Support and representation for those in greatest need. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Principle 3 – Prevention

Prevention of harm or abuse is paramount. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health services.

Principle 4 – Proportionality. Proportionality and least intrusive response appropriate to the risk presented

Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle 5 – Partnerships. Local solutions through services working with their communities

Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

Principle 6 – Accountability. Accountability and transparency in delivering safeguarding

Services are accountable to the public and to their governing bodies. Working in partnership entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

RESPONSIBILITIES OF ORGANISATIONS WORKING WITH ADULTS AT RISK

- Organisations must ensure that all staff and volunteers are familiar with policies relating to Safeguarding Adults, that they know how to recognise abuse and how to report and respond to it.
- Organisations should ensure that staff and volunteers have access to training that is appropriate to their level of responsibility and will receive clinical and/or management supervision that allows them to reflect on their practice and the impact of their actions on others.
- All staff within the organisation have a duty to report promptly any concerns or suspicions that an adult at risk is being, or is at risk of being, abused.
- Actions to safeguard the adult from abuse should always be given high priority by all organisations involved. Concerns or allegations should be reported immediately.
- Organisations working to safeguard adults at risk should ensure that the dignity, safety and wellbeing of the individual are a priority in their actions.
- As far as possible, organisations must respect the rights of the person causing, or alleged to be causing, harm. If the person alleged to have caused harm is also an adult at risk they must receive support and their needs must be addressed. Every effort must be made to ensure that adults at risk are afforded appropriate protection under the law.
- Organisations may have their own internal operational procedures in the procedures to follow when raised concerns regarding the safeguarding of an individual but these must refer and adhere to the Public Interest Disclosure Act (PIDA) 1998.

CONSENT

It should always be a priority to share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in public interest. You will need to base your judgement on the facts of the case in safeguarding to consider whether the adult at risk can give informed consent. If they are deemed competent and have a sound understanding of the raised concerns, then consent should be sought for example:

- An activity that may be abusive. If consent to abuse or neglect was given under duress (e.g. because of exploitation, pressure, fear or intimidation), this apparent consent should be disregarded
- A Safeguarding Adults investigation/assessment going ahead in response to a concern that has been raised. Where an adult at risk with capacity has decided that they do not want action to be taken and there are no public interest or vital interest considerations, their wishes must be respected. The person must be given information and can consider all the risks and fully understand the likely consequences of that decision over the short and long term.
- The recommendations of an individual safeguarding plan being put in place.
- A medical examination.
- An interview
- Certain decisions and actions taken during the Safeguarding Adults process with the person or with people who know about their abuse and its impact on the adult at risk.

LEGISLATION

The Data Protection Act 1998:

For personal data to be lawfully processed the conditions of Schedule 2 of the Data Protection Act (1998) must be met. In accordance with the Data Protection Principle, personal data must be processed fairly and lawfully, for example, by notifying the data subject why the information is being processed.

Schedule 2 of the Act: *Any disclosure must satisfy one of the conditions in Schedule 2 and respect of the sensitive personal data, at least one of the conditions in Schedule 3*.

The first condition in Schedule 2 is where the subject has consented to the disclosure and is in accordance with the guidance on confidentiality. If consent cannot be gained, one of the other conditions in schedule 2 must be met for any disclosure of personal data to be lawful.

There are exemptions to the above rules within the Act. The rule can allow the data controller the ability to disclose personal data without breaching the general presumption not to disclose personal data, as set out in the Act. These exemptions are available where in circumstances where the Act recognises that the public interest requires disclosure of personal data. The decision whether to disclose at this point lies with the data controller; this is where information sharing protocols sets it.

It is recommended that caution be exercised when relying in an exemption and that:

- A written record of the reasons why a disclosure was made
- What evidence was considered when reaching that decision
- And what exemption was utilised
- And a copy of the disclosed information is kept
- And that a Central register of disclosures is kept

Any personal data items included in the Information Sharing Protocol for Safeguarding Adults should always be treated securely and confidentially. Transfer of information within and between agencies should be subject to the terms and guidance of the Data Protection Act principle 7, on security.

Any sharing of personal data should be made in accordance with the disclosing organisation's internal data security/data protection policies, having due regard to the sensitivity of the information and appropriate method of transfer. Where emails are used to send data, they should be encrypted or password protected.

THE MENTAL CAPACITY ACT (2005)

The Mental Capacity Act 2005 is a legal framework that protects people who may lack capacity to make decisions for themselves. It also sets out how decisions should be made on their behalf. The act covers all sorts of decisions, from life-changing events to everyday matters. The presumption is that adults have mental capacity to make informed choice about their safety and how they live their lives. Every time we become involved on a safeguarding issue we need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take.

Choice - Choices are personal preferences that inform and support the decisions we make about our own lives. In order to support choices, we should offer people options in relation to, for example: Food, clothing, sleep patterns, socialising, recreation and place of worship.

Benefit - by incorporating 'choice' into practice you will be respectful and professional in your approach and shall aim to maximise the individual's level of participation in any given task. Giving the service user choice shifts the balance of power from the care worker to a more equal one in which the individual can take ownership of their care.

Risk - not incorporating choice into your practice, you may be depriving the individual of their freedom, basic human rights and therefore acting unlawfully and unprofessionally.

The Mental Capacity Act 2005 (MCA) states the following:

"…A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain"

According to the principles of the MCA:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.

Adults at risk must be offered support services that are appropriate to their specific needs. If someone has been assessed and is not deemed to have the mental capacity to make safeguarding decisions, decisions will be made in their best interests as set out in the MCA 2005 and the MCA Code of Practice. All decisions taken by professionals about a person's life should be timely, reasonable, justified, proportionate, ethical and fully recorded.

HUMAN RIGHTS ACT 1998

Living a life that is free from harm and abuse is a fundamental human right for every person and an essential requirement for health and well-being. Safeguarding adults is about safety and well-being but providing additional measures for those least able to protect themselves from harm or abuse.

Human rights are contained in the European Convention on Human Rights. The Human Rights Act 1998 integrated the Convention into UK law whereby organisations should avoid putting in place excessive rules and measures to safeguard vulnerable adults.

Human rights particularly relevant in safeguarding vulnerable adults are:

- The right to life (article 2)
- The right not to be tortured or treated in an inhuman or degrading way (article 3)
- The right to liberty and security (article 5)
- The right to respect for private and family life, home and correspondence (article 8)
- The right to freedom of expression (article 10)

THE EQUALITY ACT 2010

The Equality Act 2010 provides a legislative framework to protect the rights of individuals and provide equality of opportunity for all, especially vulnerable people. All organisations and individuals that provide a service to the public or a section of the public are obliged to adhere to this legislation. The Act makes it unlawful to treat a disabled person unfavourably because of an issue arising from or as a consequence of a person's disability. The Act states that people with a 'protected characteristic' must be protected from direct or indirect discrimination on grounds of their:

- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion belief or non- belief
- Sex
- Sexual orientation
- Age

Therefore, anyone working with vulnerable adults is formally required to:

- Follow the legal guidelines and company policies that apply to equality and diversity regulations.
- Observe and report any signs of abuse, harassment or discrimination, particularly if vulnerable disabled people are involved.
- Nurture positive relationships between different groups of people.
- Promote positive attitudes towards disabled people, including positive actions to help people with protected characteristics overcome disadvantage.
- Involve people in decisions regarding their health and social care, and their access to services.

GUIDANCE ISSUED BY THE REGULATORY AUTHORITIES

Clinical governance and adult safeguarding: *an integrated process*, Department of Health 2010

Aims to encourage organisations to develop local robust arrangements to ensure that adult safeguarding becomes fully integrated into NHS systems. This will result in greater openness and transparency about clinical incidents, learning from safeguarding concerns that occur within the NHS, clarity on reporting and more improved positive partnership working. It outlines the standards of competence the public can expect to receive from professionals and organisations charged with safeguarding adults.

Safeguarding Adults in the NHS: *The role of the service managers, practitioners and the boards*. Department of Health 2011

Provides information and guidance to the mentioned group of professionals, urges them to set strategic objectives aimed at safeguarding adults. The guide emphasises the need for professionals to see all safeguards as core business, where they are expected to set standards for their work, which subsequently helps the practitioners to identify concerns about vulnerable individuals/patients and also provide early warnings about poor practices within the service.

Safeguarding is a sensitive issue therefore professional judgement is required followed by accurate records. This guidance emphasises the importance of training needs relevant of adult safeguarding.

CARE QUALITY COMMISSION (CQC): *Our Safeguards Protocols*

The primary role of the CQC is to make sure that providers have appropriate systems in place to safeguard people who use the service, and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service. They will also ensure that when they receive safeguarding information they will pass it on in a timely manner to the local authority and/or the police. Please be aware that the CQC are the regulators of health and adult social care services.

Duty of Candour:

The Duty of Candour is a new Care Quality Commission (CQC) regulation for health and social care providers with the intention of promoting open and honest communication between staff and service users. It was introduced for NHS bodies in England from November. This is a binding regulation that lists the requirements that providers must follow when providing treatment or care and where serious incidents occur. Any provider that seeks to register with the CQC, or is registered with the CQC, must show compliance with this.

Key Principles

1. Open discussions between themselves and the healthcare provider.
2. Acceptance from the healthcare provider that this discussion will take place at an early stage.
3. A non-defensive approach to information gathering and sharing between themselves and the healthcare provider.
4. Engagement and discussion between themselves and the healthcare provider with regards to any investigations, and the outcomes from these.
5. An apology in relation to the incident.

Safeguarding adults at risk of harm: *A legal guide for practitioners Social Care Institute for Excellence.*

This guide outlines the legal basis for the safeguarding of vulnerable adults at risk of harm. This is intended to give practitioners useful legal pointers. Further advice should be sought where necessary as the law is constantly changing and each case is different and should be taken on its merit.

INFORMATION SHARING PROTOCOL

Information Governance (IG) is the legal framework that governs the use, transfer and storage of sensitive information and is regulated by the NHS Act 2006, Health and Social Care Act 2012, Data Protection Act 1998 and the Human Rights Act 1998. To ensure the safe and beneficial exchange of information on individuals in receipt of health and social care and to work with partner agencies, all organisations are required to look at their flows and methods of transferring such information.

"*When it comes to sharing information, a culture of anxiety permeates the health and social care sectors. Managers who are fearful that their organisations may be fined for breaching data protection laws, are inclined to set unduly restrictive rules for information governance.*" (*Caldicott. F*, 2013)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251750/9731-2901141-TSO-Caldicott-Government_Response_ACCESSIBLE.PDF

CALDICOTT PRINCIPLES

In 1997 Dame Fiona Caldicott formed a committee, commissioned by the Chief Medical Officer, to discuss the issues relating to the retention of personal confidential data as described in the Confidentiality – NHS Codes of Practice. The review was undertaken due to raised concerns that patient confidentiality was being undermined by the development of information technology within the NHS, and the need to put in place safeguards.

The 'Caldicott' principles and its recommendations apply specifically to patient-identifiable information, and emphasise the need for controls over the availability and access to such information. As a result, each NHS organisation has been appointed a Caldicott Guardian who has specific responsibilities to oversee the ongoing process of audit, improvement and control of medical records.

There are seven Caldicott principles that apply to the handling of patient-identifiable information:

1. Justify the purpose(s)
Every proposed use of transfer of personal confidential information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don’t use identifiable information unless it is absolutely necessary
Personal confidential information items should not be included unless it is essential for the specific purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. **Use the minimum necessary patient confidential data**
Where use of personal confidential information is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

4. **Access to patient confidential information should be on a strict need to know basis**
Only those individuals who need access to personal confidential information should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls of splitting data flows where one data flow is used for several purposes.

5. **Everyone with access to personal confidential information should be aware of their responsibilities**
Action should be taken to ensure that those handling personal confidential information, both clinical and non- clinical staff, are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. **Comply with the law**
Every use of personal confidential information must be lawful. Someone in each organisation should be responsible for ensuring that the organisation complies with legal requirements.

7. **The duty to share information can be as important as the duty to protect patient confidentiality.**
Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

SAFEGUARDING ALERTS AND DISCLOSURES

A Safeguarding Alert occurs when the first worker who becomes aware of the concerns of abuse reports them as soon as possible to the correct point within their organisation. The adult at risk and/or their representative should be involved in the safeguarding process from the outset through to its completion. In line with the Mental Capacity Act 2005 (MCA) an assumption of capacity should be made unless there is reason to suspect this is not the case.

During the investigation, the Investigation Manager and Investigating Officer should actively seek to involve the person by taking care to promote and ensure the person's right to make choices and decisions for themselves. Where there is evidence that the person lacks capacity then the Mental Capacity Act and Code of Practice should be followed. Once they have done so, any immediate protection needs will be addressed.

Decisions undertaken by practitioners/professionals to safeguard vulnerable adults will be made with the concerned adult's consent and full participation unless the adult's mental capacity assessment suggests that they need an advocate to make a decision on their behalf. This must be made in the best interest of the adult concerned and if appropriate, on what is known of their wishes prior to losing their capacity (Standard 9 of the Safeguarding Adults Framework).

It is important to speak to your manager to find out who the appropriate figure in your organisation to talk to about a Safeguarding concern is. If a crime has been committed or the person is in immediate danger, then the police must be informed in the first instance.

PROCEDURES

Safeguarding Adults Procedures: *recommended timeframes of action* **(by Safeguarding Adults Framework, good practice procedures)**

- **Alert** (Immediate action to safeguard anyone at risk)
- **Referral** (Within the same day)
- **Decision** (By the end of the working day following the one which the safeguarding referral was made)
- **Safeguarding assessment strategy** (Within five days)
- **Safeguarding assessment** (Within four weeks)
- **Safeguarding plan (**Within four weeks of the safeguarding assessment being completed**)**
- **Review** (within six months)
- **Recording and Monitoring** (ongoing)

All health and social care providers will have adult safeguarding policies and procedures in place. These will be in accordance with the legislation, national framework and guidelines.

Priority 1 – Critical: The impact of risk in this level:

- Life is or will be threatened and or;
- Significant health problems have developed or will develop

Priority 2 – Substantial: the impact of risk in this level:

- There is or there will be partial choice and control over immediate environment
- Abuse or neglect has occurred or will occur

Priority 3 – Moderate: The impact of this risk in this level:

- There is or will be an inability to carry out activities of daily living
- Normal day-to-day roles will be affected including family and social roles.

Priority 4 – Low: The impact of the risk in this level:

- There is or there will be an inability to carry out one or more of the activities of daily living or roles such as family and social.
- Social support systems and relationships may not be maintained

SAFEGUARDING STANDARDS

The following will be standard procedures following alleged abuse within this standard:

Standards for Alert

All health and social care providers will have adult safeguarding policies and procedures in place. These will be in accordance with current legislation, national framework and guidelines.

The following will be standard procedures following alleged abuse within this standard:

- Emergency assistance is readily available when concerns of abuse or neglect are made
- Where there is evidence that a crime has been committed, the police are contacted immediately
- Forensic and other evidence should not be contaminated
- Any information given by the adult concerned is listened to and recorded carefully, however the person should not be questioned to avoid distress. Questioning can be done at a later stage. Immediate questioning may contaminate the evidence as well.
- A decision is made the same day as to whether to refer the matter to the multi-agency safeguarding adults' team. Those who receive an alert should stay calm, not showing any shock or disbelief and listening carefully to what is being said and not making at subjective comments or asking probing questions.
- Those receiving an alert need to have an empathetic approach and show some concern and confirm that information will be treated seriously however should avoid giving answers that may jeopardise the reported case.
- They will need to inform the adult that feedback will be given to them as soon as the relevant departments have been notified and a contact person at this stage may be given if known.
- They should be told that they can use the contact details any time they needed to talk further about the case.
- Details of the abuse are recorded on the day the abuse alert is made
- The alleged abuser is not to be contacted until a safeguarding assessment strategy is agreed. An exception to this is unless it is part of the emergency action to suspend internal staff in response to the allegation.
- Support should also be given to those who have raised the abuse concerns
- The adult at risk should be given confirmation that the issues raised are being considered.

There is usually a multi-agency format used by all the agencies when recording any safeguarding information following an alert.

Standards for Referral Process:

Key points to remember:

- The referral process is made very simple
- The referral is made accessible to the public as well as to all other staff members in all the related organisations.
- The raised concern is made known to the multi-disciplinary team.
- Consent is gained for the referral from the mentally capable adult who is thought to be experiencing abuse/neglect unless there is an overriding public duty to act otherwise (i.e. where gaining consent may put the individual at further risk).

Standards for the Decision Process:

Safeguarding Managers have the responsibility to decide whether there are appropriate procedures in place to address raised concerns.

The following process should be implemented:

- The referrer receives a response giving appropriate information about how the referral will be dealt with (time frames to be closely applied). If the referrer is a partner organisation the information is recorded
- All adults covered by the Safeguarding Adults policy experiencing abuse/neglect receive a safeguarding assessment (e.g. in a health and social care setting) and for those who are not, their concerns will be directed to the appropriate services and this action will be recorded.

The safeguarding manager must ensure:

1. That the time frames are adhered to when dealing with the initial referral.
2. The decision to act on the referral if deemed appropriate is recorded.
3. That there is a clear framework agreed on a multi-agency basis for deciding the level of agency with which to pursue the next step of the procedure.
4. That if there is an immediate need for one or more adults to be protected or taken to a place of safety, that action is passed on to the relevant person within the organisation and that protection is implemented and recorded as soon as possible. All other partner organisations are expected to be notified. An example could be a nursing home where is it is alleged that one or more members of staff are abusing residents. The relevant regulatory bodies/ Care Commissioner, local authorities and the police are made aware of the allegations.

Standards for the safeguarding assessment strategy

All those involved in the case will initially liaise by telephone, virtual meetings or encrypted e-mails or if not encrypted use anonymous coding to protect identity of the victims to develop a strategy. Once a time frame has been agreed, a face-to-face Safeguarding Adults strategy meeting is agreed and all members of the multi-disciplinary team involved meet to discuss the abuse concerns.

The lead person ensures that the time frames are adhered to. In most cases the safeguarding manager will be the one coordinating such arrangements.

Key points for these standards are:

- The timing is determined by the level of risk otherwise the recommended time frames are adhered to
- A clear terms of reference (framework) is determined and agreed
- Adults or their advocate, where there is a need for representation (if the adult cannot be personally available, e.g. those with lack of capacity to make informed decision, following a comprehensive assessment) should attend.
- If for any reason the adult will not be present but has capacity, their views need to be taken and included in that agenda for discussion and a feedback given thereafter.
- The perpetrators of abuse are only included in exceptional cases and with the consent of the victim, where this should be recorded and appropriate safeguards are in place. There may be times when the organisation is the perpetrator of the abuse and in such cases, representatives may not be allowed to attend the strategy meeting unless they give evidence. In such circumstance, the strategy discussion is held with the regulatory body.

There is a clear framework of aims and outcomes for the strategy discussion and it is often shared in writing by all participants before the discussion:

These may include the following:

1. Addressing immediate risk
2. A plan for carrying out safeguarding assessment
3. The right, well-being and safety of the people who may be at risk
4. Safeguarding rights of whistle blowers.

- All information is shared in accordance with the information-sharing framework.
- All the organisations have a responsibility for being proactive with valuable information that will help resolve the case of abuse.
- Any action to be taken is well documented and all those given a task will be expected to carry it out and report back to the appointed delegated team members within the specified time frames.
- Any assessment or investigation is led by the agency with appropriate legal powers.
- A strategy plan should be in place which clearly stipulates the roles and responsibilities of each agency
- There should be minimal disruption to the service being rendered to the victim
- Action concerning the perpetrators of abuse is adequately coordinated so as to reduce or minimise risk to victims and whistle-blower's.
- There should be an agreed communication plan between the agencies involved to avoid missing out on vital information.

Standards for the Safeguarding Assessment/Investigation

Fact finding about abuse/neglect is started. This could be in a form of an ordinary organisational investigation, criminal investigation and or a disciplinary investigation depending on the nature and extent of the abuse. A thorough assessment of the risk is initially undertaken so that an appropriate plan of action can be followed.

The purpose of an investigation is:

- To gather relevant information and evaluate it objectively to substantiate or discount the allegation concern reported
- To reach a recommended finding, or findings, based on the evidence, that an allegation is either: substantiated, not substantiated or inconclusive
- To ensure the resulting Safeguarding Plan reflects any emerging information.

For any investigation, there is often a lead agency responsible i.e.

1. *Criminal - Police,*
2. *Breach of care standards - CQC,*
3. *Unresolved complaints in the health care setting - Health Care Commission*
4. *Breach of professional code of conduct – Professional Regulatory Body*

Key points in this standard:

- The Police will notify the agencies responsible if they are have considered the abuse as a criminal case and will state when their criminal investigation will take place.
- Each agency clearly outlines the support given to the victim and the whistle-blower's
- All those agencies involved in the case of abuse will share their investigations if undertaken individually, but individuals undertaking the investigation on behalf of their organisation need to be given support and supervision where necessary. At the end of the investigation they need to make a comprehensive record of their findings and actions undertaken.
- There should be clear protocols of who carries out the investigations, but as already stated it is recommended that the agency with legal powers should do the investigation
- The adult who suffered abuse/neglect will be the first to be interviewed if they are deemed to have no cognitive impairment that could hamper their mental capacity to make informed decisions during the interview. Use of independent advocacy can be used if need be.
- The information they provide will be shared with other agencies on a need to know basis using the information sharing protocol.
- All documents and evidence (forensic and other) will be appropriately stored using the powers of partner agencies where necessary.

The Investigation Report should provide a summary of the investigation, the Investigating Officer's key findings, an evaluation of the information gathered and the Safeguarding Plan for the adult at risk.

It should set out the following objectives:

- A summary of concerns or allegations and categories of abuse being investigated
- A summary of the investigation
- In certain circumstances, it should be appropriately anonymised
- A chronology of key events and actions should be included either as part of the Investigation Report or attached as an appendix
- A relationship chart of key individuals and services involved in the investigation
- A clear and concise analysis of the information gathered through the investigation and whether this has supported, disproved or had no relevant bearing on whether harm has occurred and any differing views in relation to this
- Conclusions that may be drawn from the information. This should include whether the Investigating Officer has found the allegation of harm to be substantiated, not substantiated or inconclusive
- A clear recommendation or recommendations, referring to the evaluation and analysis of the information
- The adult at risk/their representative's views of the investigation and its findings, including how they want to manage their own safety, and the support they may want or need following the safeguarding process
- The outcomes the adult at risk/their representative wishes to achieve from the safeguarding process, and their views of the investigation and its findings
- The views of the person/service alleged responsible and any recommended outcomes and actions relating to them
- Any recommended further actions to reduce or address risk including strategic actions or learning; and referrals to professional bodies

Standards for the Safeguarding Plan

The safeguarding manager will coordinate a multi-agency response to the risk of abuse that has been identified. They will have developed a clear framework of who will attend and participate in assessing the results of the investigations.
Key points for this standard:

During this meeting the involvement of the adult is important unless otherwise not possible but all representatives are required to attend in the best interest of the adult.
All the written reports will be discussed during a multi-disciplinary meeting
A joint report will be written based on the findings of the investigations
A decision is then made based on the outcome of the investigations/interviews, undertaken. This may include whether abuse/neglect took place or not or may still yet to be reported or if there is thought to be an ongoing risk of abuse/neglect or not.
Where it is confirmed that abuse has taken place a safeguarding plan is made
Relevant authorities will be involved at this stage e.g. the police and legal services and the use of relevant legislation followed (Safeguarding Principle 5 and 6)
Any person entitled to 'special measures' under 'Achieving Best Evidence' is identified and a referral made to Witness Support services.
Positive action is put in place to prevent the perpetrator from abusing or neglecting in the future (Safeguarding Principle 3)
The agreed feedback from the strategy meeting will be discussed and the outcome of the issues raised will be communicated to those who reported abuse/neglect.
All participating agencies will ensure all documents will be secure.

Standards for the Review

The reason for a review is to find out if the Safeguarding Plan has been implemented by the relevant agencies and whether it benefits the adult.
Key points for this standard:

- Agreed time scales are adhered to
- Any changes in circumstances to be made know to all the participating agencies immediately

Standards for recording and monitoring

Key points for this standard:

- Each organisation keeps their comprehnsive records securely
- All records should be stored at a central secure place for easy access by all the agencies
- The lead person to the process ensures that all the record from all those participating are available for storage
- All those participating agencies keep a copy of the record they submitted concerning the issues.
- The length of time the records are stored will be in accordance with the national regulations. This should be made known to all the participating agencies.
- The participating agencies agree on the monitoring and recording process and compliance to the agreed measures is followed.
- All those participating need to communicate difficulties encountered in fulfilling obligations to the safeguarding plan
- There is an agreed multi-agency protocol for serious cases including death.
- Cases selected for serious case reviews should be agreed by the participating agencies.

MANAGEMENT OF SERIOUS INCIDENTS

Circumstances surrounding each incident vary in terms of levels of harm and numbers of people involved, risk of exposure, financial loss, media interest and the need to involve other reporting stakeholders. Therefore, each incident should be proportionate to the scale, scope and complexity.

Steps to manage serious incidents:

- Identification and Response: The first instance by the provider is to ensure that those affected by the incident are attended to in order to reduce the harmful effect. It is also important to identify where other agencies need to be brought into the management of a serious incident when required
- Serious incidents in foundation trusts should be reported to the lead commissioning body
- All identified serious incidents must be notified to the relevant bodies without delay and within two working days of the incident occurring.

When a serious incident occurs, it can have a devastating and far-reaching effect. It will have an impact on those directly involved; patients, relatives, staff or visitors, but also on the reputation of the healthcare organisation, the service provider or the professional involved.

The serious incident reporting framework uses the systems-improvement approach. This acknowledges that causes of incidents cannot simply be linked to the actions of individual people hence the use of the systems approach. It supports openness, trust and continuous learning and service improvement. It highlights where engagement with relevant bodies for full investigation and identification of learning from a serious incident is needed.

CONCLUSION

Every organisation that provides healthcare must have robust activities that are dedicated to reducing the risk or potential for harm and abuse to its service users and employees.

These may include:

- Criminal Record Bureau checks for staff
- Safer recruitment procedures
- Multi-disciplinary care planning
- Patient-centred/person-centred care planning
- Intentional rounds (nurses checking all their patients)
- Falls assessment, prevention and pathways
- Harm-free care
- Safeguarding policies, procedures, guidelines and essential training updates for staff

Risk reporting and learning from incidents helps to improve the standards of patient care and to reduce the incidence of further reportable cases.