Kinwood care limited - Management

Safeguarding Adults Policy

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	**1 2, 13, 17, 18, 20**

CQC Single Assessment Framework Topics

Safe Topic Areas:

Safeguarding

Caring Topic Areas:

Kindness, compassion and dignity

Treating people as individuals

Independence, choice and control

Responsive Topic Areas:

Providing information

Listening to and involving people

Equity in access

Equity in experiences and outcomes

Well-led Topic Areas:

Shared direction and culture

Partnerships and communities

Please see the ‘Quality Statements’ section for full guidance

Scope

This policy should be read in conjunction with the local authority policies and procedures for safeguarding adults. This organisation provides the regulated activity of accommodation for people who require nursing or personal care.
Adults at risk can be at risk of abuse or exploitation within their family, peer groups, from the wider community, care staff, healthcare workers. Abuse takes several forms both physical and mental and can involve criminal activity, fraud, exploitation, or extremism.
Staff have a duty of care to recognise and raise safeguarding concerns and this policy supports staff in meeting their safeguarding adults’ responsibilities.
In addition, this organisation recognises that children are at risk of abuse. Staff may encounter people we support’ or their family’s children when delivering services and become concerned for their safety (Please see separate ‘Safeguarding Children in an Adult Setting Policy’).

Equality Statement

Our organisation is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Key Points

- Our organisation works to ensure care and treatment will not disregard the needs and human rights of the adult and will not operate in such a way that would control or restrain any person without the specific legal consent and least restrictive practice plans in place and approved by the local authority DoLS team.
- Empowerment – people are to be supported and encouraged to make their own decisions and provide informed consent.
- Prevention - it is better to act before harm occurs.

- Proportionality – always use the least intrusive response appropriate to the risk presented.
- Protection – provide support and representation for those in greatest need.
- Partnership – everyone has a part to play in preventing, detecting, and reporting neglect and abuse; you may need to work with a variety of other organisations.
- Accountability – we are accountable for our actions and must be transparent in our safeguarding practice.
- Contracts of employment, codes of conduct and safeguarding frameworks such as the Care Act require all care staff to exercise a duty of care and, where necessary, take action for safeguarding and crime prevention.

Policy Statement

This policy is applicable to all staff and management and must be read and used by all staff within the organisation relevant to their role and the delivery of services.
The organisation aims to ensure that adults at risk are protected from harm and this organisation fully adheres to all safeguarding legislation. Safeguarding duties apply to an adult at risk who:

- Has need for care and support (whether the local authority is meeting any of those needs or not), and
- Is experiencing, or is at risk of, abuse or neglect, and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

These duties extend to other organisations, including statutory agencies such as the local authority, the NHS, ICB and Police.
The Registered Manager is responsible for reviewing all guidance, regulatory and legislation changes and updating policies, procedures, and training as appropriate. The Registered Manager should also be supported by the Nominated Individual in ensuring there is a positive safeguarding culture within the organisation. This policy has been written in accordance with the NICE guideline NG189, 'Safeguarding Adults in Care Homes.' It is underpinned by Care Act 2014 statutory guidance and the Making Safeguarding Personal framework.

The Policy

It is the organisation's policy to provide management and staff with training, policies and procedures which integrate with the local authority Safeguarding Adults Board's policies and procedures. Staff will be required and encouraged to raise concerns in an open and honest environment through the agreed processes. The organisation will promote a culture in which safeguarding is openly discussed and abuse and neglect can be readily reported. Staff will be provided training and quarterly supervision which will include competency assessment on safeguarding policies and procedures.

In addition, the organisation will investigate, in line with the local authority safeguarding team's instructions, and audit all safeguarding allegations made against staff, management and the service to identify themes and trends, learning and continuous improvement actions.

Care Act (2014)

The Care Act (2014) defines adult safeguarding as:
'Protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.'

People with care and support needs, such as older people or people with disabilities, are more likely to be abused or neglected. They may be less likely to identify abuse themselves or to report it. Adults with communication difficulties can be particularly at risk because they may not be able to alert others. Sometimes people may not even be aware that they are being abused, and this is especially likely if they have a cognitive impairment. Abusers may try to prevent access to the person they abuse.

Managers and staff have a duty to safeguard adults at risk from harm, abuse, or neglect and to co-operate with other agencies to achieve:

- Knowledge of when to report concerns and who to report to.
- An emphasis on prevention, information and advocacy.
- A balance of choice, control and safety – helping you to 'Make Safeguarding Personal' (The Care Act, 2014).

The Registered Manager, or designated safeguarding lead, Emmi Storer- Care co-ordinator is responsible for identifying best practice updates, e.g. NICE and CQC guidance, and will disseminate pertinent learning from various sources including the NHS England's case reviews and Safeguarding Adults Board's Safeguarding Adults Reviews relevant to the service and annual report. In addition, they are responsible for recording and reporting/notifications to appropriate agencies, including CQC.

The Six Principles

These six principles apply to all health and care settings and all safeguarding work should be based on them:
Empowerment - People being supported and encouraged to make their own decisions and informed consent.
Prevention - It is better to act before harm occurs.
Proportionality - The least intrusive response appropriate to the risk presented.
Protection - Support and representation for those in greatest need.

Partnership - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.
Accountability - Accountability and transparency in safeguarding practice.

What is Abuse?

Abuse and neglect can take many forms. The organisation should not be constrained in its view of what constitutes abuse, neglect or harm and should always consider the circumstances on a person-centred basis.

Employees do not need to know what type of abuse or harm is happening to report concerns, they simply need to state what was seen or heard that has caused concern.

Incidents of abuse may be one-off or multiple and, in a service, can affect one person or more. Managers, when investigating and reviewing incidents, should look beyond single incidents or individuals to identify patterns of harm. Repeated instances of poor care may be an indication of more serious problems and organisational abuse. It is important that information is recorded and appropriately shared so that themes, trends, and patterns can be identified.

For types of abuse please see 'Appendix 1' which provides an indicative list for review.

Preventative Measures

The organisation aims to support all people we support, legal representatives, advocates and their families in maintaining their safety and putting in preventative measures against abuse.

The organisation will work with the people we support, their families, health and social care professionals and local authorities to reduce the risk of abuse to adults at risk. This will include the following:

- Working with people we support to develop a strong support and positive network of professional agencies, family and friends to support their well-being.
- Reduce isolation through these networks and support people with their favourite activities.
- Provide signposting information on support and social activities to minimise isolation.
- Support individuals to maintain regular medical and dental appointments and to take good care of themselves.
- Support people to have access to communication to friends and external agencies, e.g. access to own phone and can send and open their own mail/email.
- Supporting individuals to assert their right to be treated with dignity and respect.
- Provide accessible information so people we support know their legal rights.
- Work with people we support to access health and social care professionals, social services, the Police and other relevant agencies when they need help.

The organisation will provide relevant policies and procedures to people we support and their family, e.g. 'Complaints,' 'Safeguarding' and 'Whistleblowing' policies and procedures at the commencement of the service. Where appropriate to the needs of the person we support or family member these will be provided as an easy read document. In this way, people we support and family members will know how to raise concerns regarding safeguarding or seek help.

Consent and Mental Capacity Act 2005 (MCA)

Any intervention to protect a resident must be carried out with the consent of the person we support concerned, there may be occasions where their consent may not be valid, e.g. due to consent needing to be over-ridden by the organisation's duty to protect others when there are concerns regarding wider groups of vulnerable adults or children or when a criminal offence has taken place.
Where the individual has been assessed as lacking capacity to make the decision on whether to give or withhold consent, then the organisation will act in the best interests of the resident in line with the MCA (2005) and the associated MCA 2005 code of practice.

Employer's Responsibility

The Care Act (2014) requires employers who are aware of abuse or neglect in their organisation to correct this and protect the adult from harm as soon as possible and inform the local authority, CQC and ICB (where the latter is the commissioner).

Employee's Responsibility

All staff have a duty to report and escalate concerns of abuse they identify or suspect as part of their role within the organisation and when delivering care to residents.
This includes, identifying abuse by staff, family members, carers or other third parties, e.g. healthcare professionals. Concerns may include abusive behaviour, poor professional practice, neglect, or any other issues which staff observe or suspect.
See 'Appendix 2' for indicative roles and responsibilities.

In addition, where there is a concern a crime has been committed or that the individual is in danger, then the Police must be contacted on 999 immediately.

What to do:

If you suspect abuse or neglect, you must act on it. Do not assume that someone else will. Depending on the immediate risk/concern, and who the alleged abuser is, think about who should be immediately notified. For example:

- The Registered Manager.
- A healthcare professional or the NHS 111 service if there is a serious medical issue.
- The Police (999) or other emergency services if the resident is in immediate danger or you suspect a crime.

If you witness, suspect, or are told about potential harm/abuse:

- Listen carefully, remain calm and try not to show shock or disbelief.
- Support the person to speak freely.
- Acknowledge what is being said.
- Take it seriously and treat the person raising the concern with dignity and respect.
- Provide reassurance to the person reporting, that they have done the right thing in reporting the abuse.
- Do not ask probing or leading questions which may affect credibility of evidence.
- Use simple and open questions.
- Be open and honest and do not promise to keep a secret.
- Consider use of communication aids or translator, if required, to involve the person we support.
- Take account of individual differences.
- Provide emotional support.
- Reassure the person raising the concern (where it is safe and appropriate to do so) that you have a duty to act under the Safeguarding Adults procedure.
- Seek consent to share information if the resident has capacity and if this does not place you or them at increased risk.
- If the victim requests that the matter should not be reported, the staff member should inform them that they have a duty to report the matter. The staff member should then reassure the resident that the matter will not be taken further than the Manager without their consent unless there are exceptional circumstances (e.g. if a crime has been committed or other residents may be at similar risk of being harmed in the same way).
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm, always discuss this with your Line Manager.
- Reassure the person raising the concern that the service will take steps to support the adult at risk and to minimise the risk of further harm/abuse.
- Inform your Line Manager **immediately** of the concern/allegation being raised. If your Line Manager is not available, you must report this to the designated person in charge of safeguarding the service.
- Ensure those at risk of harm are safe from the alleged perpetrator.
- Preserve any evidence. The designated safeguarding lead must liaise with the Police, in addition to the local authority safeguarding team, if a crime has been committed/is suspected.
- Do not investigate the situation yourself. Follow the guidance and instructions from the local authority safeguarding team and/or the Police.

Recording Information Relating to an Incident

The designated person in charge of safeguarding will ask you to make a legible, factual, timely and accurate record of the witnessed, suspected, or disclosed abuse. What happened, what actions

were taken and who has been notified?

Information recorded for sharing with the Social Services Department or to the Police must be as accurate as possible, as it may be used in any subsequent legal action; hence there is the necessity for making a factual, detailed record of the following:

- The person we support's:
- Name
- Address
- Date of birth
- The allegation.
- Description of visible bruising or other injuries.
- The person we support's account, write this using their own words if possible, of what has happened, including how any bruising/injuries were inflicted.
- Observations made by the person recording the information.
- Times, locations, dates, and other relevant information.
- Distinction between fact, opinion and hearsay.
- Recorder's relationship to and knowledge of the adult.

Immediate Assessment of Risk and Safeguarding Actions

The designated person in charge of safeguarding in the service will undertake a holistic and thorough assessment considering the person we support's emotional, social, psychological, and physical presentation as well as the identified clinical need. This safeguarding lead needs to be alert to:

- Seek medical assistance for the person we support if required.
- Are there others at risk, e.g. to children or other adults at risks?
- Is immediate protection required?
- Environmental factors, e.g. signs of neglect, the reactions and responses of other people with the persin we support.
- Inconsistencies in the history or explanation.
- Personal presentation, e.g. is the person unkempt, dehydrated, showing physical indicators of abuse?
- Delays or evidence of obstacles in seeking or receiving treatment.
- Does the person we support have capacity for the decision required?
- Are they able to give informed consent or is action needed in their best interests?
- What are the person we support's views/wishes, cultural differences or religious beliefs? What would they like to happen next?
- Are there valid reasons to act even without consent? E.g. where others are at risk; need to address a service failure that may affect others, or a crime has been committed.

- Has a crime been committed, and should the Police be informed? Do not tamper with evidence that may be required for a police investigation.
- Is the action that is being considered proportionate to the risk identified?

Information Sharing

- Where there are safeguarding concerns, staff have a duty to share information.
- It is important to remember that in most serious case reviews, lack of information sharing can be a significant contributor when things go wrong.
- Information should be shared with consent wherever possible. A person's right to confidentiality is not absolute and may be overridden where there is evidence that sharing information is necessary to support an investigation or in best interests, e.g. in the interests of public safety, police investigation, implications for regulated service.
- Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
- Be open and honest with the person from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe, or inappropriate to do so.
- Seek advice if you are in any doubt, without disclosing the identity of the person where possible.
- 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 judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case.
- Consider safety and well-being. Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.
- Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.
- The service shall keep a record of the decision to share information or not, and the reasons for it. If the information is shared, then record what you have shared, with whom and for what purpose.

Any information disclosed should be:

- Clear regarding the nature of the problem and purpose of sharing information.
- Based on fact, not assumption.
- Restricted to those with a legitimate need to know.
- Relevant to the specific incident.
- Strictly limited to the needs of the situation at that time.

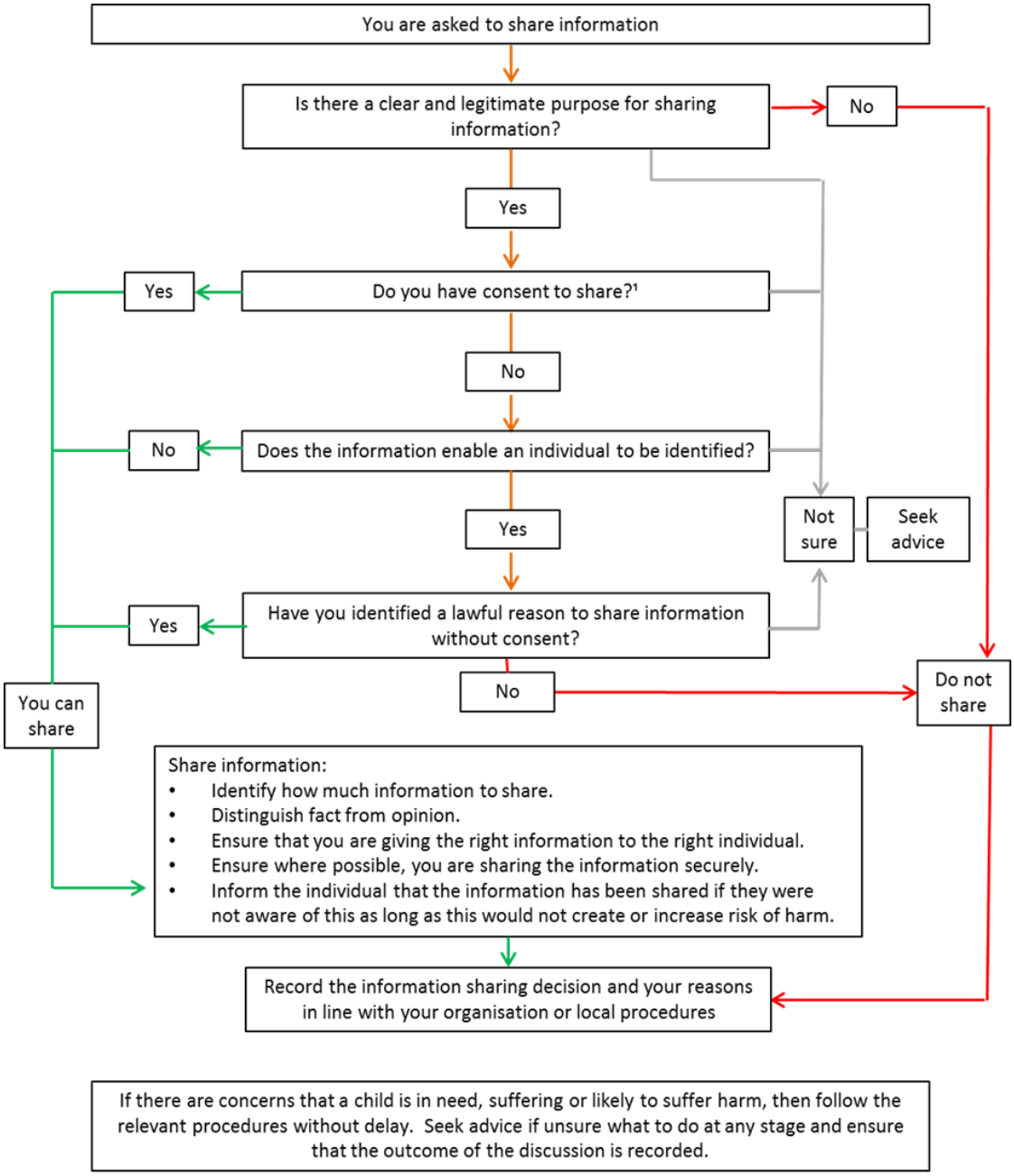
- Recorded in writing with reasons stated.

Sharing data when someone lacks mental capacity:

- Can the person we support give consent to disclosure of information?
- You have a responsibility to explore approaches to help them understand.

In some instances, the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case any disclosure of information needs to be considered against the conditions set out in the Data Protection Act and Best Interests under the Mental Capacity Act.

The contact details for the Adult Safeguarding Team are: Social Care Direct: Telephone: 0345 8 503 503 Email: social_care_direct@wakefield.gov.uk



1. Consent must be unambiguous, freely given and may be withdrawn at any time

Allegations About Staff

Where staff have concerns or receive a safeguarding allegation or complaint that raises safeguarding issues about a member of staff, they must immediately report this to their Line Manager who will contact the local authority safeguarding team. This applies to all adults whether paid or working in a voluntary capacity including agency workers on or off premises or sites. The safeguarding officer will advise you on the action to take next.

Staff Safeguarding Responsibility

Any suspicion of a safeguarding situation must be reported as a matter of course to the Registered Manager or in their absence, to the senior manager on duty at the time.

The designated safeguarding lead is: Emmi Storer- Care co-ordinator

Concern about a colleague can also be raised through the 'Whistleblowing Policy.'

If the safeguarding concern involves the Manager, the report should be made to the nominated individual- Chris Storer, who will then take advice and follow the appropriate guidance. Where required, support should be given to the reporting staff member.

It is good practice, as soon as is possible, for contemporaneous notes to be recorded for future reference.

It may be necessary to suspend a staff member from duty if allegations of abuse have been made against them. HR advice should be sought, and an immediate decision may have to be made to take action to protect the adult or other people we support against any potential risk of harm (e.g. suspension without prejudice, supervised working). Actions taken will need to be compliant with employment law and the employee will have a right to know, in broad terms, that allegations or concerns have been raised about them.

The Registered Manager will, following consultation with the local authority Safeguarding Adults Team and the Police where appropriate, inform the subject of the allegations. If it is deemed appropriate to conduct an investigation prior to informing those who are implicated, a clear record will be made of why the Registered Manager took the decision.

The Registered Manager will balance supporting the alleged victim, other people we support and the wider staff team, the investigation and being fair to the alleged perpetrator.

The Registered Manager will be aware of how safeguarding allegations can affect the subject of the allegation and take steps to protect them from any victimisation or discriminatory behaviour. They will also nominate someone to keep in touch with them (if they have been suspended), throughout the enquiry, and ensure they have information about any employee assistance programmes and/or counselling services.

The alleged perpetrator will be considered innocent until proven otherwise. Suspension offers protection for them as well as the alleged victim and other residents and enables a full and fair investigation to take place.

All allegations will be followed up regardless of whether the person involved resigns their post, responsibilities, or a position of trust, even if the person refuses to co-operate with the process. Compromise agreements, where a person agrees to resign without any disciplinary action and agreed future reference, will never be used.

The Registered Manager will consider what further action, if any, should be taken in consultation with the local authority safeguarding team.

If a member of staff who has been suspended is returning to work, the Registered Manager will arrange a return to work meeting and agree what further support they may require.

The outcome of a safeguarding case conference may be used to support the next steps. When it is concluded there is insufficient evidence to determine whether the allegation is substantiated, the chair of the safeguarding strategy meeting will ensure that relevant information is passed to the Registered Manager.

When an allegation of abuse or neglect has been substantiated, and the staff member's employment has been terminated, or they have been moved to a position in a non-regulated activity, or they have resigned prior to termination of their contract, a referral to the professional or regulatory body and to the Disclosure and Barring Service (DBS), will be made in line with the organisation's legal duty.

The Registered Manager will review the procedures to help prevent similar events from occurring in the future and to ensure lessons learnt are implemented.

Supporting Other Staff

Registered Managers will take instruction from the local authority safeguarding team to ensure they understand what information they can share with other staff at each stage of the enquiry. Safeguarding enquiries can be stressful and affect morale. The Registered Manager will be open to answering questions from staff, think of other ways they can support staff and direct staff to other sources of support if required.

Adults at Risk not Engaging with Services and at Serious Risk of Harm

Where an adult at risk has capacity, but is at risk of harm and declines the support services provided, then providers and commissioners are required to consider:

- Peoples' Rights: People we support have a right to receive advice and support to make choices about their service needs but take personal risks, as long as there is no impact on other adults and/or children.
- Duty of Care: Risk assessment and risk management must establish the impact of risks to people we support that agencies must take action to protect individuals.
- For an action to succeed in negligence there must be an identified duty of care. An action will only be successful where a duty of care is breached through negligent acts or omissions and where injury or worse is suffered as a result.
- Local authorities, health care, private care providers and staff owe a duty of care to individuals to whom they provide services.

- Information: Should be provided in a form that meets the person we support's needs.
- Equality Act 2010: Services and support must be provided with dignity and respect and not discriminate because of any protected characteristic.
- Engagement: All effort must be made to engage with the person we support identifying increases in dependency or harm, as well as actions that will minimise or eliminate risks.

Partnership and communication between agencies supporting the resident is key to ensuring the individual does not become isolated, and that regular contact is maintained to ensure the opportunity to take up support is available when required.

Guidance on Pressure Ulcers and Safeguarding

Pressure ulcers are a significant risk for people we support who have limited movement, may be bed or chair bound and suffer from issues with continence. It is estimated by the NHS that 80-95% of pressure ulcers are preventable with the appropriate care and support. Pressure ulcers are painful and debilitating and can lead to infection and death through complications.
Pressure ulcers are considered an important part of the wider safeguarding agenda and each local safeguarding team has guidance in place to ensure that people with pressure ulcers are referred into the safeguarding process appropriately which aligns with the NHS reporting mechanisms.

Please see 'Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern.'

Reporting of Pressure Ulcers

- All care staff are responsible for reporting pressure ulcers.
- All care staff should complete a body map for any mark, bruise, tear or pressure sore observed, this should be uploaded to the person we support's records/electronic records with accompanying notes and descriptions (see 'Appendix 2: Adult safeguarding decision guide, page 13').
- If new, staff should inform the Registered Manager to ensure management plan is developed to prevent harm
- An incident form will be completed for all identified category 2 - 4 pressure ulcers
- Report multiple site grade 2, and individual site grade 3 – 4 pressure ulcers to CQC and safeguarding (use 'Appendix 1: Adult safeguarding decision guide, page'2).
- Grade 4 pressure ulcer require a full root cause analysis investigation.
- GP will be informed that the resident has a pressure ulcer.
- The organisation will fully comply with its duty under regulation 20 the Duty of Candour, to act openly, honestly and to formally apologise where through its, or its staff, actions residents have come to harm, or could in the future, or have died.
- Please see the 'Pressure Ulcer Prevention Policy.'

Training

All staff and managers must read this safeguarding policy and will receive safeguarding training as part of their induction (see the 'Staff Induction Policy') and annual safeguarding updates thereafter. The safeguarding induction training will be completed no later than six weeks after commencement in the role.
The Registered Manager will ensure that agency staff working at the home have completed the necessary safeguarding training for their role and that they understand the local authority safeguarding policy and procedure.
Following this training staff will:

- Understand the national and local context of safeguarding and protection from abuse.
- Be able to identify the six core principles of safeguarding.
- Understand their and others' safeguarding responsibilities.
- Know how to recognise types of abuse including organisational abuse and neglect (See 'Appendix 1').
- Understand the difference between poor practice and neglect.
- Know how to act on suspected or alleged abuse including reporting abuse or neglect.
- Understand how to deal with and preserve evidence.
- Know how to access and use the 'Whistleblowing Policy.'
- Understand how to escalate concerns if the organisation's response is not appropriate or effective, or if the concern relates to the Registered Manager.
- Know how to reduce the likelihood of abuse.
- Know how to recognise and report unsafe practices.
- Understand principles for online safety.
- Be able to make the links between safeguarding and domestic violence.
- Understand confidentiality and data protection.
- Understand duty of candour.
- Also receive Mental Capacity training (see the 'Mental Capacity Policy').

The Registered Manager will ensure staff have time allowed for safeguarding induction, and annual training. They will assess competence following training and via supervision periodically. The Registered Manager will request feedback on induction and training and help staff to increase their confidence in managing safeguarding concerns.

The Registered Manager will have training in safeguarding, and will:

- Monitor performance.
- Assess knowledge and competence at least annually.
- Provide learning and development opportunities when identified or required and at least annually. These may include reflective learning, opportunities to explore problem solving, and explanations of concepts and terminology if needed (to ensure accessible information).

Supervision and Team Meetings

Supervision should include discussions about identifying and responding to safeguarding concerns, reporting and/or challenging poor practice and the staff view of the organisation's culture in relation to safeguarding.

Supervision, team meetings and other learning opportunities should be used to:

- Share best practice in safeguarding, including learning from Safeguarding Adults Reviews.
- Challenge poor practice or discuss uncertainty around safeguarding practice.
- Discuss the differences between poor practice (which is not necessarily a safeguarding issue) and abuse or neglect (which are safeguarding issues).

Registered Managers should make particular efforts to involve staff who work alone or who get very little direct oversight (for example night staff).

Whistleblowing Policy

Staff should be aware of the company's 'Whistleblowing Policy' and use this where appropriate to raising a concern if you feel unable to raise this internally.
Staff must consider the safety of the individual person we support and the circumstances they are in, and if they believe them to be in danger then contact the emergency services immediately (without putting themselves at risk) by dialling 999.
If staff do not believe the person we support is at immediate risk, and they do not feel they can discuss this internally within the company, they should contact the Adult Safeguarding Team as soon as possible by phone or email on the contact details provided within this policy. They can also contact the Care Quality Commission (CQC) on 03000 616161 or enquiries@cqc.org.uk to raise a concern about an organisation.

Seeking Feedback about Safeguarding

This organisation will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of safeguarding concerns and how these have been identified, reported, managed and resolved. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

References and Further Reading

LA Multi-Agency Adult Safeguarding Guidance/Protocol

- https://www.wakefield.gov.uk/adult-social-care/safeguarding-adults-from-abuse

The Care Act 2014

Care Act 2014: Safeguarding Adults

Equality Act 2010

Equality Act 2010: Chapter 1 (Protected Characteristics) Chapter 2 (Prohibited Conduct) and Chapter 3 (Services and Public Functions)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Safeguarding Vulnerable Groups Act 2006

Royal College of Nursing, 2024 Adult Safeguarding: Roles and Competencies for Health Care Staff, RCN

Social care for older people with multiple long-term conditions, NICE

Making Safeguarding Personal, Local Government Association

Making Safeguarding Personal Booklet, Local Government Association

Pressure ulcers: how to safeguard adults

Channel and Prevent Multi-Agency Panel (PMAP) guidance

National FGM Centre

Quality Statements

Safeguarding

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Providing information

We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

Equity in access

We make sure that everyone can access the care, support and treatment they need when they need it.

Equity in experiences and outcomes

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Independence, choice and control

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and well-being.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Shared direction and culture

We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Key questions and quality statements - Care Quality Commission

Appendix 1: Types of Abuse

Types of abuse

The following is not an exhaustive list but provides a wide range of examples of the types of abuse adults and children may experience. If staff are unsure whether the behaviour that they are

witnessing adults and/or children being subjected to is abuse they should raise their concerns, which will be discussed with the local authority safeguarding teams for guidance.
NICE guidance NG189 uses the terms 'consider' and 'suspect' to define the extent to which an indicator suggests abuse or neglect, with 'suspect' indicating a stronger likelihood of abuse or neglect.

- To 'consider' abuse or neglect means that this is one possible explanation for the indicator.
- To 'suspect' abuse or neglect means a serious level of concern about the possibility of abuse or neglect.

Physical Abuse

Including assault, hitting, kicking, slapping, punching, pushing, misuse of medication, inappropriate restraint or inappropriate physical sanctions.
Consider physical abuse when people we support:

- Have unexplained marks or injuries (for example, minor bruising, cuts, abrasions or reddened skin).
- Tell you or show signs that they are in pain, and the cause is unexplained (for example, the pain is not caused by a pre-existing medical condition).

Suspect physical abuse when people we support:

- Have multiple or repeated marks or injuries (for example, bruising, cuts, lesions, loss of hair in clumps, bald patches, burns and scalds).
- Have injuries that are very unlikely to be accidental (for example, grip marks, cigarette burns or strangulation marks).
- Are being restrained without authorisation (either by direct restraint or by being confined to a particular area).
- Flinch when approached, or change their behaviour (for example, acting subdued) in the presence of a particular person.
- Have fractures that cannot be explained.
- Have their activity limited by misuse of medication, or covert administration when not medically authorised.

Act immediately to safeguard people we support and contact the Police if you witness an assault or are told that a person we support has been assaulted.

Be aware that injuries can be caused by other people we support

See 'Physical abuse, SCIE.'

Sexual Abuse

Including rape and sexual assault, sexual harassment, or sexual acts to which the adult has not consented or was pressured into consenting. This can include 'non-contact' sexual acts such as indecent exposure, online abuse, non-consensual pornographic activities.

Be aware that people we support have the right to engage in sexual activity if they have the mental capacity to consent. See policy on sexuality and relationships for guidance.

Consider sexual abuse when people we support:

- Are spoken to or referred to using sexualised language.
- Experience any instances of sexualised behaviour or teasing.
- Show unexplained changes in their behaviour, such as:
- Resisting being touched.
- Becoming aggressive or withdrawn.
- Having trouble sleeping.
- Using sexualised language.
- Showing highly sexualised behaviours.
- Show changes in their relationships (for example, being afraid of or avoiding particular residents, family members or members of staff).

Suspect sexual abuse if a person we support has an intimate relationship with a member of staff.

Suspect sexual abuse when people we support who lack capacity to consent to intimate or sexual relationships:

- Report being inappropriately touched or experience unwanted sexualised behaviours.
- Have unexplainable physical symptoms that may be associated with sexual activity, such as itching, bleeding or bruising to the genitals, anal area or inner thighs.
- Have unexplained bodily fluids on their underwear, clothing or bedding.
- Are involved in a sexual act with another person, including their husband, wife, partner, or another person we support.
- Have a sexually transmitted infection.
- Become pregnant.

See 'Sexual abuse, SCIE.'

Sexual Exploitation

Means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including profiting monetarily, socially, or politically from the sexual exploitation of another.

This may take the form of:

- Individuals being groomed as children or young people.

- People we support being at risk and threatened or coerced, have drug dependencies and/or mental health needs which are exploited.
- People we support with learning disabilities may be led into harm because they believe they are being offered friendships.

Controlling Behaviour

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, depriving them of their means for independence or resistance and escape and managing their daily behaviour.

Coercive Behaviour

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten the victim into doing as the perpetrator requires.

Forced Marriage

Forced marriage and/or luring someone overseas for the purpose of marriage is a criminal offence. Perpetrators will automatically be prosecuted where it is overwhelmingly in the public interest to do so, however victims should be able to choose how they want to be assisted, which may include Forced Marriage Protection Orders.

A forced marriage is where one or both spouses do not or, in the case of people who lack the mental capacity to make the decision, cannot consent to the marriage. Violence, threats and other forms of coercion are often involved and can include emotional force, physical force, or the threat of force or financial pressure.

Modern Slavery

The Modern Slavery Act 2015 encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive, and force individuals into a life of abuse, servitude and inhumane treatment. Trafficking is the movement of people by means such as force, fraud, coercion, or deception with the aim of exploiting them. It is a form of Modern Slavery. People can be trafficked for many different forms of exploitation such as forced prostitution, forced labour, forced begging, forced criminality, forced marriage, domestic servitude or forced organ removal. Trafficking does occur within the UK, and it is paramount for organisations to have on their radar.

See 'Modern slavery, SCIE.'

Human Trafficking

Is the illegal movement of people through force, fraud, or deception with the intention of exploiting them, typically for the purposes of forced labour or sexual exploitation. Men, women, and children are forced into a situation through the use (or threat) of violence, deception or coercion. Victims

may enter the UK legally or on forged documentation or secretly under forced hiding, or they may even be a UK citizen living in the UK who is then trafficked within the country but should not be confused with people smuggling, where the person has the freedom of movement upon arrival in the UK. There is no 'typical' victim of human trafficking and modern slavery. Victims can be men, women and children of all ages, ethnicities, nationalities and backgrounds. It can, however, be more prevalent amongst the most vulnerable members of society, and within minority or socially excluded groups.

Cuckooing

Cuckooing is a practice where people take over a person's home and use the property to facilitate exploitation.

There are different types of cuckooing including using the property to/for:

- Deal, store or take drugs
- Sex work
- Them to live
- Financially abuse the tenant

The most common form of cuckooing is where drug dealers take over a person's home and use it to store or distribute drugs. People who choose to exploit will often target the most vulnerable in society. They establish a relationship with the vulnerable person to access their home. Victims can be people who misuse drugs or alcohol, or people with learning difficulties, mental health issues, physical disabilities or are socially isolated.

Internet/cyberbullying

Can be defined as the use of technology, and particularly mobile phones and the internet, to deliberately hurt, upset, harass, or embarrass someone else. Often an extension of face-to-face bullying, with the technology providing the bully an alternative route to their victim, or it can be motiveless. Cyberbullying can use practically any form of digital media, from text and image messages on mobile phones, to blog and social networking posts, or emails and instant messages, to malicious websites created solely for the purpose of intimidating an individual or abuse during an online game.

Psychological Abuse

Psychological abuse involves the regular and deliberate use of a range of words and non-physical actions used with the purpose to manipulate, hurt, weaken, or frighten a person mentally and emotionally; and/or distort, confuse, or influence a person's thoughts and actions within their everyday lives, changing their sense of self and harming their well-being.

This includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, bullying,

isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Consider psychological abuse when people we support:

- Are addressed rudely or inappropriately on any occasion (verbally or non-verbally).
- Are prevented from speaking freely.
- Are deliberately and systematically isolated by other people we support and/or staff.
- Have information about their own care systematically withheld from them by the care home.
- Are not involved in planning their own care, or when changes are made to their care without discussion or agreement.
- Are denied a choice on any occasion (for example, around activities of daily living or freedom of movement).
- Are denied unsupervised access to others.
- Show significant and otherwise unexplainable changes in their behaviour, including:
- Becoming withdrawn
- Avoiding or being afraid of particular individuals
- Being too eager to do anything they are asked
- Compulsive behaviour
- Not being able to do things they used to be able to do
- Not being able to concentrate or focus

Suspect psychological abuse when people we support:

- Are repeatedly addressed rudely or inappropriately (verbally or non-verbally).
- Are shouted at or verbally threatened.
- Are repeatedly humiliated, belittled, or have their opinions or beliefs undermined.
- Are getting married or entering a civil partnership if you are concerned that they have not consented or lack capacity to consent to this.
- Are denied access to independent advocacy.
- Are repeatedly denied choices (for example, around their activities of daily living or freedom of movement).

See 'Psychological or emotional abuse, SCIE.'

Financial or Material Abuse

Including theft, fraud and exploitation, coercion in relation to an adult's financial affairs or arrangements, including pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. This can include 'cuckooing,' where a person's property is taken over and used for illegal activities.
Be aware that not having systems to take care of residents' money and possessions is a form of organisational abuse and can lead to financial abuse.

Consider financial and material abuse when people we support:

- Do not have their money or possessions appropriately recorded by the care home.
- Lose money or possessions.
- Do not have access to their money, or to possessions that they want or need.
- Are not routinely involved in decisions about how their money is spent (for example if they do not get a personal allowance), or how their possessions are used.
- Appear to have bought things they do not need or invested money in things where they may lack capacity to make informed decisions.
- Find the person managing their financial affairs to be evasive or uncooperative.
- Family or others show unusual interest in their assets.
- Have unusual difficulty with their finances and are uncharacteristically protective of money and things they own.

Suspect financial and material abuse when people we support:

- Have their money spent, or their possessions or property used by other people, in a way that does not appear to benefit the resident (for example, their personal allowance being used to fund staff gifts, or misuse of loyalty card points).
- Have treasured personal items constantly go missing.
- Get married or enter a civil partnership if they are likely to lack capacity to consent to this.
- Change a will under duress or coercion.
- Sign a lasting power of attorney when they do not have the mental capacity to make this decision.
- Personal financial information is not kept confidential.

See 'Financial or material abuse, SCIE.'

Neglect and Acts of Omission

Including wilfully ignoring medical or physical care needs, failure to provide access to appropriate health and social care, including not supporting a person to access clinical appointments and support, the withholding of the necessities of life (such as medication), adequate nutrition and heating or depriving someone of stimulation or company, adaptations, equipment, or aids to communication. Pressure ulcers are one of the many indicators for neglect. See the 'Pressure Ulcer Prevention Policy' for more information.

Consider neglect if people we support:

- Are not supported to present themselves the way they would like (for example haircuts, makeup, fingernails and oral hygiene and care).
- Are given someone else's clothes to wear.
- Occasionally have poor personal hygiene or are wearing dirty clothes.
- Are wearing clothing that are unsuitable for the temperature or the environment.

- Have lost or gained weight unintentionally.
- Do not have access to food and drink in line with their dietary needs.
- Have repeated urinary tract infections.
- Are not getting care to protect their skin integrity, potentially leading to pressure ulcers.
- Do not have opportunities to spend time with other people, either virtually or in person.
- Uncharacteristically refuse or are reluctant to engage in social interaction.
- Do not have opportunities to do activities that are meaningful to them.
- Do not have access to medical and dental care.
- Are occasionally denied access to communication and independence aids (such as hearing aids) contrary to their care and support plan.
- Have not received prescribed medication, or medication has been administered incorrectly (for example, the wrong dose, timing, method, or type of medication).
- Do not have access to outdoor space, fresh air and sunlight.
- Are not given first aid when needed.

Suspect neglect when people we support:

- Do not have an agreed care and support plan.
- Are not receiving the care in their agreed care and support plan.
- Have deteriorating physical or mental health or mental capacity, and there is a lack of response to this from staff.
- Live in a dirty, unhygienic, or smelly environment.
- Repeatedly have poor personal hygiene or are wearing soiled or dirty clothes.
- Are malnourished.
- Are frequently and uncharacteristically not engaging with other people, or in activities that are meaningful for them.
- Have only inconsistent or reluctant contact with external health and social care organisations.
- Have restricted access to food or drink, if this is not part of their agreed care and support plan.
- Are not kept safe from everyday hazards or dangerous situations.
- Repeatedly do not receive prescribed medication, or medication has been repeatedly administered incorrectly (for example the dose, timing, method, or type of medication).
- Are denied communication or independence aids (such as hearing aids, glasses or dentures), contrary to their care and support plan.

See 'Neglect or acts of omission, SCIE.'

Self-neglect

Covers a wide range of behaviour such as neglecting to care for one's personal hygiene, health or surroundings, and can include behaviour such as hoarding and non-attendance at necessary health/dental appointments. Consideration must be given to the impact on other family members

and/or the wider care home, mental capacity legislation and whether this gives rise to a safeguarding concern.

Responses to self-neglect should include:

- Thinking about why the resident is refusing support.
- Considering their capacity to understand the potential impact of the self-neglect.
- Asking them why and whether they want a different kind of support.
- Make a safeguarding assessment based on their specific needs and risks.

See 'Self neglect, SCIE.'

Domestic Abuse

The cross-government definition of domestic violence and abuse is 'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, honour-based violence, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.' The offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act (2015).

See 'Domestic violence or abuse, SCIE.'

Discriminatory Abuse or Hate Crime

Harassment, slurs, violence, and unequal treatment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation (known as 'protected characteristics' under the Equality Act (2010).

Consider discriminatory abuse when people we support:

- Are denied choices about the care and support that they receive.
- Are receiving care and support that does not take account of their personal or cultural needs, or other needs associated with protected characteristics under the Equality Act 2010.
- Show any of the indicators of psychological abuse, if these are associated with protected characteristics.

Suspect discriminatory abuse when people we support:

- Are not treated equitably and do not have equal access to available services.
- Experience humiliation, violence or threatening behaviour related to protected characteristics.
- Are not provided with the support they need, for example, relating to their religious or cultural beliefs.
- Are denied access to independent advocacy.

See ‘Discriminatory abuse, SCIE.’

Female Genital Mutilation (FGM)

FGM is a criminal offence, child abuse and violence against women or girls. Existing structures of Adult and Children Safeguarding processes, policies, procedures and reporting mechanisms are used to manage these cases, unless the local authority provides alternative guidance.

The following principles when responding to those at risk of, or who have undergone FGM:

- Safety and welfare of the child is the main objective.
- Agencies must act with interests of the rights of the child as stated in the United Nations Convention on the Right of the Child (1989).
- FGM is illegal in the UK.
- FGM is an extremely harmful practice, responding to it cannot be left to personal choice.
- Accessible, high quality and sensitive health education, police, social care, and voluntary sector services must underpin all interventions.
- FGM is often an embedded social norm within communities, engagement with families and their communities plays an important role in contributing to ending it.
- All decisions or plans should be based on high quality assessments, undertaken by suitably trained staff.

FGM comprises all procedures involving partial or total removal of the external female genital organs or any other injury to the female genital organs for non-medical reasons. FGM is most often carried out on young girls aged between infancy and 15 years old. Whilst there is a mandatory requirement to report incidents of FGM for children and young people this is not a requirement for adult women but is good practice to report.

World Health Organisation (WHO) provide four classification types for FGM:
Type 1 – Clitoridectomy - Partial or total removal of the clitoris (a small, sensitive and erective part of female genitalia) and in very rare cases, the prepuce (the fold of skin surrounding the clitoris).
Type 2 – Excision - Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the lips surrounding the vagina).
Type 3 – Infibulation - Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris.
Type 4 – Other - All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, and cauterising the genital area.

Please see the National FGM Centre for more information.

Statistics are gathered via NHS services in the UK who, through treatment, identify those who have been subjected to FGM.

The duty to report any FGM allegations is set out in the local authority multi-agency guidance, which will be developed from the outline process in Chapter 14 of the Care Act 2014. The local authority will provide specific guidance for actions to be taken by the provider if appropriate.

Fabricated and Induced Illness

Sometimes a child is taken to see a health practitioner frequently. There can be various reasons for this, such as a child with an underlying physical or mental health condition, or a parent or carer who may be overanxious and asking for advice and support. However, in some cases, parents or carers have fabricated or induced illness in a child. If you are concerned about a parent or carer's behaviour, the presentation of a child, or the frequency of accessing health services, seek the advice of the named professional for your organisation.

There are three main ways of the carer fabricating or inducing illness in a child. These are not mutually exclusive and include:

- Fabrication of signs and symptoms; this may include fabrication of past medical history.
- Fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids. This may also include falsification of letters and documents.
- Induction of illness by a variety of means.

Exploitation by Radicalisation

Anti-terrorism PREVENT strategy, of which CHANNEL is part, Channel and Prevent Multi-Agency Panel (PMAP) guidance is led by the Home Office. The aim is to stop people becoming terrorists and/or supporting extremism. Local organisations have a role to play in safeguarding people who meet the criteria, and contact should be made with the Police regarding any individuals who present a concern regarding violent extremism.

Prevent (Radicalisation)

Prevent is a government strategy that seeks to stop people becoming terrorists and supporting violent extremism. There are numerous government departments and local partners involved in the strategy, and one of the main organisations involved are healthcare services.

Prevent has three main objectives, which are to:

- Tackle the causes of radicalisation and respond to the ideological challenge of terrorism.
- Safeguard and support those most at risk of radicalisation through early intervention, identifying them and offering support.
- Enable those who have already engaged in terrorism to disengage and rehabilitate.

Many of the vulnerabilities that terrorist radicalisers prey on are often the same as those exploited by groomers in other forms of exploitation and the method/approach may be very similar. The

Prevent Strategy promotes early intervention to protect vulnerable adults from being drawn into terrorism.

Staff who engage with the public will, through training and guidance, understand what radicalisation means and why people may be vulnerable to being drawn into radicalisation, extremism and possibly terrorism. They should be aware of what the term ‘extremism’ means and the relationship between extremism and terrorism.

We will work with staff to identify what measures are available to support people and stop people becoming drawn into terrorism and how to challenge the extremist ideology. Signposting information will be identified on how to obtain support for people being exploited by radicalising influences.

The key message is that all staff must escalate a concern and have confidence that each issue will be taken seriously, handled appropriately and that, where necessary, specialist advice will be available.

All staff will receive the appropriate level of Prevent training. The basic premise of the training is that staff should:
Notice – there is a change in the behaviour of a resident or staff member, or you see something that concerns you.
Check – discuss your concerns with your manager.
Share – your concerns with your manager.

If staff believe that an adult at risk is being exploited or radicalised, then safeguarding procedures will be used to raise concerns, which may then escalate concerns to Channel (the multi-agency early intervention process designed to safeguard adults and children at risk from being drawn into violent extremist or terrorist behaviour).

Where there is an immediate risk to an individual or others contact should be made to the Police via 999. Where there is no immediate threat referral should be made through normal safeguarding procedures.

Organisational Abuse

An incident, or a series of incidents, involving ongoing ill treatment. It can be through neglect or from poor professional practice resulting from inadequate structure, policies, processes, and practices within an organisation. This may range from isolated incidents to continuing ill treatment in a care or nursing home.

Organisational abuse (also known as institutional abuse) is distinct from other forms of abuse or neglect because it is not directly caused by individual action or inaction. Instead, it is a cumulative consequence of how services are managed, led and funded. Some aspects of organisational abuse may be hidden (closed cultures), and staff may act differently when visitors are there (disguised

compliance). Organisational abuse can affect one person or many residents. Therefore, it is important to consider each unique case, and the impact on individual residents, as well as the whole care home.

Consider organisational abuse when:

- Safeguarding leadership or governance arrangements are unclear (for example, there is no Registered Manager or delegated safeguarding lead).
- Managers rarely or never observe their staff at work or are rarely, or never, available to speak to people we support (or their families and carers), staff, or other professionals.
- Managers are overly controlling, constantly interfere when staff are working, and stop staff from trying to improve resident safety or care.
- The care home does not have policies and procedures covering:
- Safeguarding
- Whistleblowing
- Complaints
- The care home has policies and procedures covering safeguarding, whistleblowing and complaints, but does not use them.
- The care home policy and procedure on safeguarding is inconsistent with the Care Act 2014 or the NICE guidance this policy is based on.
- people we support, visitors, staff, and other people working in care homes do not have access to policies and procedures covering safeguarding, whistleblowing and complaints.
- The care home enforces blanket procedures and decisions, regardless of people we support's individual needs, wishes and circumstances, and which generally conflict with safeguarding policies and procedures.
- The care home does not explain the concepts of safeguarding, abuse and neglect to people we support.
- People we support are not involved in how the care home is run.
- Not meeting contractual or regulatory requirements.

Consider organisational abuse when care homes:

- Do not meet contractual safeguarding requirements.
- Do not meet national regulations, including the fundamental standards of quality and safety monitored by the Care Quality Commission.
- Fail to improve or respond to actions or recommendations arising from inspections or audits by professionals, commissioners and regulators (for example clinical commissioning groups, local authorities, the Care Quality Commission and Healthwatch).
- Fail to sustain improvements.
- Do not monitor the quality of their care using the Care Quality Commission's key lines of enquiry and prompts to ensure that the service is safe, effective, caring, responsive and well-led.
- Mismanagement of safeguarding concerns and poor record-keeping.

Consider organisational abuse when:

- Safeguarding issues are not always reported.
- No audits or actions are taken after a disclosure.
- There is no clear safeguarding policy or information about how to raise a safeguarding concern.
- Serious incidents are not reported (for example, unexplained deaths, serious fires, or infectious disease outbreaks).
- There is a lack of safeguarding concerns recorded or referrals made.
- The care home has poor or outdated records.
- There are inconsistent patterns of safeguarding concerns logged (for example, if all concerns originate from one member of staff, then other staff may not be taking enough responsibility for safeguarding).
- Safeguarding concerns have been reported via complaints procedures rather than through safeguarding procedures.
- The care home does not comply with Mental Capacity Act requirements on deprivation of liberty and liberty protection safeguards (when enacted).

Consider organisational abuse when:

- The care home does not have clear, safe recruitment processes (including reference checks and enhanced Disclosure and Barring Service checks).
- Staff are not properly supervised and supported, or there is no documentation that this is happening.
- There is no evidence that safeguarding training or induction is taking place.
- There are high rates of staff absence.
- Staff work excessive hours without enough breaks.
- Staff are working under poor conditions.
- There is high staff turnover and high dependency on contract or temporary staff, as this can have an effect on quality of care and service provision.
- There is evidence of poor medicines management (for example, excessive use of 'as needed' medicines).
- Restrictive practice is used, i.e:

- People we support are prevented from moving around the home freely or independently.
- Staff teams have inflexible and non-negotiable routines that do not take account of what individual people we support's want or need.
- Staff do not help people we support live as independently as they can.
- Meaningful and structured activities for people we support are not available or accessible.
- Behaviours of concern are mismanaged (for example, overuse of restrictive practices, including misuse of medication).

- Care and support plans are changed suddenly, without discussion with people we support or others involved with their care.
- People we support do not receive person-centred care, for example care is focused on completing tasks and ignores individual circumstances and preferences (including cultural preferences).
- Staff routinely make assumptions about residents or their needs and miss hidden needs or disabilities.
- Staff do not respond to requests from residents or interfere with people we support's preferences and choices.
- People we support are reluctant to ask for changes or to make complaints.
- Certain residents routinely receive preferential treatment over others.
- There are general inconsistencies in the standard of service provision.
- Failure to refer for appropriate care or support.

Consider organisational abuse when:

- People we support miss appointments or are not referred to other professionals or services (such as GPs or dentists).
- People who require independent advocacy are denied access to it.
- Financial mismanagement and lack of investment.

Consider organisational abuse when:

- There are not enough staff on each shift to meet the needs of the people we support.
- There are problems with care home equipment:

- It does not meet the needs of people we support
- It is poorly maintained
- There is not enough equipment for all people we support
- The care home admits or accepts referrals for people we support that staff do not have the skills to care for.
- There is a lack of investment in the services the care home provides, compared with the fees it charges.
- Resources (such as one-to-one support) for people we support with assessed needs are not provided, despite funding being allocated for this.
- People we support's money is not adequately protected (for example, they do not have personal allowances).
- Physical signs and lack of openness to visitors.

Consider organisational abuse when:

- The care home is dirty or smelly or is not compliant with basic infection control (for more information about infection control see the NICE quick guide on helping to prevent infection).
- Call bells have been removed or deactivated.
- There is a lack of engagement with visitors, or places in the care home that visitors are not allowed to see.
- The care home discourages visitors without justification.
- There is a lack of engagement with the organisation the care home is part of.

Suspect organisational abuse when:

- Incidents of abuse or neglect are not reported, or there is evidence of incidents being deliberately not reported.
- There is evidence of redacted, falsified, missing or incomplete records.
- There have been multiple hospital admissions of people we support, resulting in safeguarding enquiries.
- There are repeated cases of people we support not having access to nursing, medical or dental care.
- There is frequent, unexplained deterioration in people we support's health and well-being.
- People we support's money is being misused by the care home (for example, to purchase gifts for staff or other people we support without permission).
- There is a sudden increase in safeguarding concerns in which abuse, or neglect has been identified.
- People we support are repeatedly evicted or threatened with eviction after making complaints.
- Repeated instances of people we support's, families and carers feeling victimised if they raise safeguarding concerns.
- The care home fails to improve or respond to actions or recommendations in local inspections or audit frameworks from clinical commissioning groups or the local authority, or reviews and inspections by the Care Quality Commission or Healthwatch and deteriorates over time.

See 'Organisational or institutional abuse, SCIE.'

Staff action

If you consider organisational abuse may be occurring, raise the issue with the Registered Manager, safeguarding lead or other senior member of the organisation, such as an operational lead, director or nominated individual.

Explain the impact of your concerns on residents, ask for a response from the home within a specified timeframe and check the changes do happen. If the situation does not improve, raise your level of concern to 'suspect' and take further action to alert the appropriate authorities including the local authority Safeguarding Team and CQC.

If you 'suspect' abuse or neglect:

Contact your local authority and tell them that you want to make an adult safeguarding referral.
When local authorities receive adult safeguarding referrals:

- They should gather information, under Section 4 of the Care Act. They must decide if there is reasonable cause to suspect that an adult with care and support needs is experiencing abuse or neglect and is unable to protect themselves from harm - if this criteria is met, they must conduct a Section 42 enquiry.
- If many people we support of a care home are affected, local authorities may conduct a largescale enquiry, following their own local procedures.

If you are not satisfied with the response from your local authority, you can make a complaint to the Local Government and Social Care Ombudsman and give feedback to the Care Quality Commission.

Appendix 2: Safeguarding Responsibilities by Role

Registered Manager

- To ensure that safeguarding vulnerable adults is integral to clinical governance and audit arrangements carried out by the provider.
- To ensure that the provider meets the contractual and clinical governance arrangements on safeguarding adults.
- To ensure that all staff in contact with vulnerable adults are alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.
- To regularly review safeguarding records to ensure accuracy, quality and appropriateness.
- To ensure that the provider operates safe recruitment processes in line with national and local guidance including disclosure and barring and managing allegations against staff.
- To ensure safeguarding responsibilities are reflected in all job descriptions.

Designated Adults Safeguarding Manager (This could also be the Registered Manager)

The roles and responsibilities do not equate to a full-time role but, where a person is identified to take on this role, these duties should be included in the job description.
The provider's safeguarding lead is Emmi Storer- Care co-ordinator who can be contacted on emmi.storer@kinwoodcare.co.uk.
The provider's Mental Capacity Act lead is paige.stevenson@kinwoodcare.co.uk.
His/her deputy is emmi.storer@kinwoodcare.co.uk.
Their role is to:

- Act as a contact on safeguarding adult and Mental Capacity Act matters; this may include requests to contribute to sharing information required for safeguarding investigations where appropriate.
- Disseminate information in relation to safeguarding adults/Mental Capacity Act to all staff members.

- Act as a point of contact for family members to bring any concerns that they have, to document those concerns and to take any necessary action to address concerns raised.
- Share information received on safeguarding concerns promptly with the safeguarding team, clarifying or obtaining more information about the matter as appropriate and as advised.
- Facilitate access to support and supervision for staff working with vulnerable adults and families.
- Ensure that the staff team complete the provider's agreed incident forms and analysis of significant events forms.
- Be fully conversant with the provider's safeguarding adults policy, the policies and procedures of the Local Safeguarding Adults Board; and the integrated processes that support safeguarding.
- Be responsible for facilitating training opportunities for individual staff groups.

Safeguarding Champions

To support:

- Individual staff members, including all employed staff and volunteers
- To be alert to the potential indicators of abuse or neglect for vulnerable adults and know how to act on those concerns in line with national guidance and the local safeguarding adult procedures.
- To be aware of and know how to access the Local Safeguarding Adults Board's policies and procedures for safeguarding adults.
- To take part in training, including attending regular updates so that they maintain their skills and are familiar with procedures aimed at safeguarding adults and implementation of the Mental Capacity Act.
- Understand the principles of confidentiality and information sharing in line with local and government guidance.
- To contribute, when requested to do so, to the multi-agency meetings established to safeguard and protect vulnerable adults.
- Recognise the importance of sharing information, in confidence and with a lead person, regarding concerns they have about a colleague's behaviour.
- To minimise any potential risk to vulnerable adults.