HALTON BOROUGH COUNCIL

HALTON SAFEGUARDING ADULTS BOARD

Criteria for Reporting Adult Safeguarding and Provider Led Concerns

April 2024

Contents

Policy Summary

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If you require this policy or any associated documents in another format (e.g. other languages, easy-read or any other format), please email details of your requirements to: ascservicedevelopment@halton.gov.uk.

Acknowledgements

Halton Borough Council would like to acknowledge that this document has been based on Knowsley Metropolitan Council Guidance: Criteria for Reporting a Safeguarding Adults Concern

Section 1

1. Introduction

Protecting vulnerable people from abuse, harm and exploitation in Halton is a clear priority for the Council and its partners. It is important to ensure that resources are targeted to ensure they are used effectively and to ensure clear indicators exist regarding procedures that should be followed.

Sometimes a concern arises which leaves managers uncertain as to whether it should be dealt with as a safeguarding matter or as one that constitutes poor practice, but does not warrant initiating the Safeguarding Adults Procedures.

In order to ensure the safety of those at highest risk of abuse and neglect it is important that the criteria for reporting is set at the right level. The aim of this guidance is to assist organisations providing or commissioning services for adults across Halton, in deciding when to initiate Safeguarding Adults Procedures. The guidance should be read in conjunction with Halton's Safeguarding Adults Policy & Procedure documents. It is the responsibility of managers in organisations to ensure that their staff are familiar with the procedures and with this guidance.

This guidance includes definitions of an adult with care and support needs (adult at risk), abuse and harm at **Section 2.** If the criteria set out in these definitions are not met then there is no requirement to raise a Safeguarding Concern. Information about Making Safeguarding Personal is contained in **Section 3.**

This guidance is based on seven areas where clarity is needed about when to report a safeguarding concern:

- Falls **Section 4**
- Incidents between adults at risk **Section 5**
- Nutrition and Hydration **Section 6**
- Pressure Area Care **Section 7**
- Missed Home Care Visit **Section 8**
- Medication Errors **Section 9**
- Provider-Led Enquiries (Care Concerns) **Section 10**

Each of these sections includes information about the specific issue. For each section there is a quick reference one-page guide or 'Easy Guidance' – contained in the Appendices.

This document is intended to offer guidance to managers in making decisions but it is acknowledged that at times there may be incidents where decision-making is not straight forward and professional judgement is required. In all cases ensure that the reasons for the decision are recorded.

If in doubt, report a safeguarding concern to the Integrated Adult Safeguarding Unit via the Council Contact Centre on **0151 907 8306**, the professionals based in the Unit will then decide how to proceed.

2. Definitions

Clarity of definitions is essential in ensuring Safeguarding Adults Procedures address concerns about the population they are intended to serve. North West Safeguarding Adults Policy defines an '**Adult at Risk' as follows.**

An 'adult with care and support needs' is someone aged 18 or over who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) 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 (Care Act 2014)

There is no requirement to use protective services for people outside of this definition.

Abuse

Although the population served is comparatively small, the definition of abuse is wide:

"Abuse is a violation of an individual's human and civil rights by any other person or persons. It can be a singular or repeated act, or a lack of action.

Abuse or neglect can be unintentional; however, the primary focus must still be how to safeguard the adult. What is important is the harm caused to the person and whether the abuse might be repeated. In assessing harm to the person this should be from their own perspective, or that of their representative.

The Care Act Guidance states that local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered.

Harm

Harm includes all harmful contact and, in particular, include: conduct which causes physical harm; conduct which causes physical harm; conduct which causes psychological harm, for example, causing fear, alarm or distress.

3. Making Safeguarding Personal

The Care Act guidance enshrines in law the principle of 'Making Safeguarding Personal' which involves asking the person at risk what they would like to happen. When a provider manager raises a safeguarding concern or provider led concern about a person using the service and that person has capacity to state their views, then the manager should ask them what they want to happen and should record this on the appropriate documentation, including the Safeguarding Concern raised to the Local Authority or the Provider Led Concern form.

Relationships and involving people from the beginning are more important than following a process; previously safeguarding has been driven by policy and practice rather than by what the person wants. **All safeguarding concerns must be reported to the local authority whether or not the person wants an enquiry to be carried out; the professionals in the Integrated Adult Safeguarding Unit will then assess the individual's wants and needs and how to proceed.**

4. Guidance for responding to Falls

Fall rates rise with age – for people over 65 years of age, 50% of those living in institutions and 66% living in nursing homes will fall at least once a year.

40% of nursing home admissions result from falls and instability.

People with dementia are known to have increased falls risk. The fact that they are more physically able but mentally impaired means that EMI (Elderly Mentally Ill) units are predictably the highest risk area for falls.

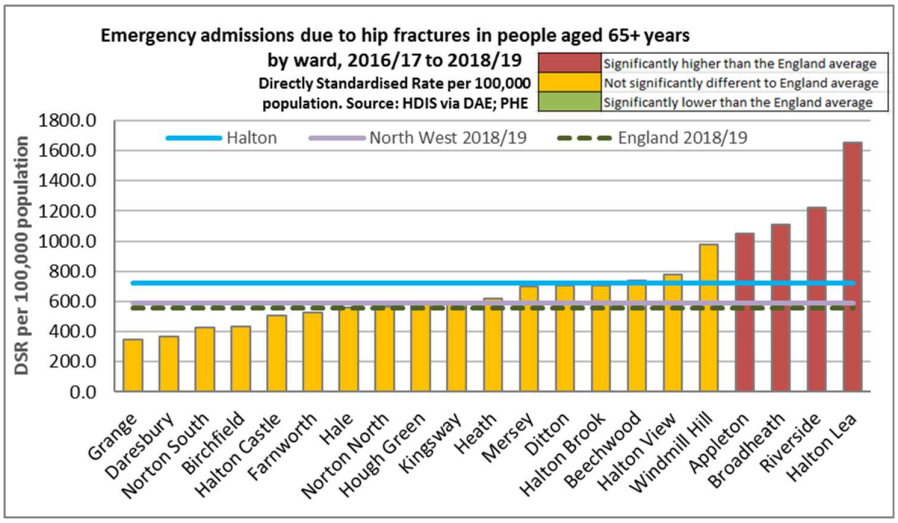
Statistics from Louise Allan (Newcastle) Falls in Dementia, say that a person with dementia is 3 times more likely to fall once in a care facility, if they have altered gait/mobility problems 8-10 times more likely and if the diagnosis is dementia with lewy bodies up to 20 times more likely to fall than the average person at home. People with dementia recover less well after a fall than those without dementia.

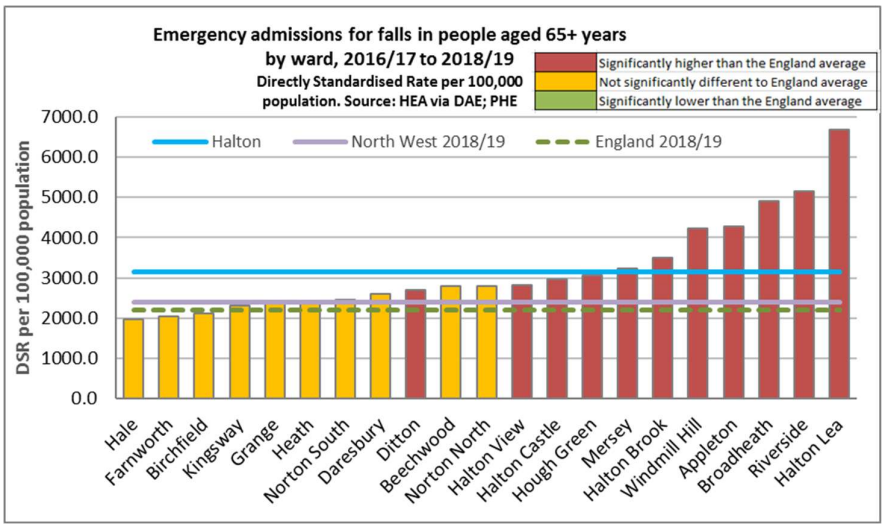
People who wake during the night to use the toilet are at particular risk.

Local Picture for Halton

In Halton, we have rates of hip fractures which are higher than the North West and England average, but not significantly so. However, the emergency admissions to hospital due to injuries from falls are significantly higher than the regional and national averages.

The graphs below illustrate the number of hip fractures and emergency hospital admissions due to injuries from falls by ward.





For further details, please refer to the Halton Falls Strategy 2018-2023

Falls Strategy 2018-2023 FINAL.doc

The consequences of older people falling

The quality of life of an older person can be significantly reduced following a fall. The effects include:

- Physical injury (50% of those who fall will show measures of increased dependency in the months following attendance at Accident and Emergency; 75% will fall again within a few weeks or months; only 50% of those hospitalised will be alive 12 months later)

- Increased social isolation
- Increased problems with activities of daily living
- Increasing tendency to depression and mental health problems
- Increasing physical and emotional dependence

Falls in Care Homes and Day Services

Many slips, trips and falls are preventable. Injuries arising from a fall can be reduced by prior intervention. Post fall assessment, review and remedial action can reduce the likelihood of further falls. It is important that service users who have fallen and those who may be at risk from falling in the future have regular reviews or reversible risk factors.

Falls Risk Assessment

Therefore, there needs to be a shared understanding that falls happen and it is not possible to prevent all falls. It is essential that in admission to a care service, a falls risk assessment is undertaken. The person using the service should be supported to make decisions about how they may reduce their risk of falling. The Care Plan must reflect the outcome of the falls assessment and should be shared with the person and their relatives.

Where there are concerns about a service user's capacity to understand the risk and implications of falling, capacity must be assessed under the Mental Capacity Act and if needed a best interest decision made to maintain the service user's safety. The outcome of this assessment must be recorded in the person's care plan.

Where a person falls and a falls risk assessment is in place which has been followed, then it is not necessary to report the incident as a Safeguarding Concern

This guidance endorses the current advice given to care services by the Falls Nurse that there should be one single document which contains evidence of:

(1) The factors contributing to any falls risk
(2) Actions taken to reduce the risk
(3) Actions yet to be carried out
(4) A statement predicting the risk of future falls – this should be based on the evidence collated and **must be discussed with the family from the outset.**

This information should appear in one document so that in the event of an enquiry of a fall, the investigator can see evidence of action taken to address risk without having to trawl through daily reports and other documents to find information.

The Falls Nurse is available for advice and consultation but it is **not** the role of this Nurse to complete assessments; this is the responsibility of the care provider. It is

expected that Care Providers complete Falls Risk Assessments for people who are a risk of falls within Halton care homes, in order to evidence Falls Prevention work and thereby avoid the need for safeguarding concerns to be raised

Where a person sustains an injury due to a fall and there is a concern that a risk assessment is not in place or was not followed, then this must be reported as a Safeguarding Concern because this amounts to neglect on the part of the care provider.

'Unwitnessed' Falls/Unexplained Injury

There has been an expectation that care providers should make Safeguarding Concerns in respect of all 'unwitnessed falls'. However, this broad approach is not helpful, nor is the use of the term 'unwitnessed fall' – if a fall was unwitnessed how can it be determined that the person fell? Could it be possible that they were pushed or knocked over by someone else? In some circumstances it may be presumed that the person fell, for example, if they are found on the floor in their room and no one else is around; but each individual incident needs to be considered according to the unique factors of the case.

On occasions 'unwitnessed falls' have been reported as Safeguarding Concerns even when the person has stated that they fell, if there is a risk assessment in place which has been followed then it is not necessary to complete a Safeguarding Concern, the person has explained what happened and abuse or neglect is not likely to have occurred.

In this context, it is more helpful to use the term 'unexplained injury' rather than 'unwitnessed fall'. In circumstances where a person has sustained an injury the manager on duty should use judgement based on the evidence available to determine what may have happened. If the person has an injury, other than a minor injury, which cannot be explained then this should be referred as a Safeguarding Concern.

Where a person has repeat unexplained injuries, then a Safeguarding Concern should be raised.

Providers are required to report to CQC any serious injuries to people who use the service (Regulation 18).

Seeking medical advice following a fall

Every fall may not require GP or hospital involvement, this will depend on the nature of the injury, the experience of staff in the care service and whether there is a trained nurse on site, expectation of family etc. If no injury is apparent, there is no observed change in function and actions and observations have been recorded, then a GP or

hospital review may not be necessary. This decision will be made by the manager or clinician on duty based on the individual circumstances of the case.

Where the person has sustained a head injury a medical assessment should always be arranged as a matter of urgency. The following definition of head injury can be found in **'Head Injury: A guide for patients and carers'. Brain and Spine Foundation 2013**

"What is head injury?

A head injury is a blow to the head from a force outside the body, like an accident, fall or attack. When the brain is damaged by such an event, this is called a traumatic fall or attack. When the brain is damaged by such an event, this is called a traumatic brain injury (TBI)

What are the symptoms?

The symptoms and effects of head injury can vary widely, depending on the level of injury and which part of the brain, if any, is injured. ***They can range from a bump or bruise on the head to loss of consciousness."***

Falls in Hospital

Falls in hospital require a different response; Hospital Trusts have their own governance arrangements in relation to patient safety, including falls, and should follow their own procedures.

Summary of when to report a Safeguarding Concern following a fall

It is important to remember that a Safeguarding Concern must be reported where there is a concern about possible abuse or neglect ***by another person*** and not because there is a general concern about a person's safety.

Where a person sustains an injury due to a fall, and there is a concern that an appropriate risk assessment was not in place or was not followed, this must be reported as a Safeguarding Concern. They key factor is that the person has experienced ***avoidable*** harm.

Where a person has an injury, other than a very minor injury, which is unexplained this must be reported as a Safeguarding Concern.

Where a person has sustained an injury which has resulted in a change in function and appropriate medical attention has not been sought, this must be reported as a Safeguarding Concern.

If in doubt raise a Safeguarding Concern, the professionals based in the Integrated Adults Safeguarding Unit will then decide how to proceed.

See Easy Guidance at Appendix 1 and FallsTriggers at Appendix 2.

5. Incidents between Adults at Risk

There may be times when the behaviour of an adult at risk towards another is abusive. Any person at risk of abuse from another is in need of protection. In deciding how to manage such incidents, it is important to consider whether the incident has caused harm or avoidable harm to the adult at risk and if so, whether this amounts to a crime requiring the involvement of the Police.

Prevention

Prevention is always the preferred option and service providers should plan the care and support they offer so that opportunities for incidents between people using the service are minimised. People using services such as day centres, care homes and supporting housing have the right to be supported in a safe environment; abuse by another adults at risk is just as harmful as abuse by anyone else.

Good practice would indicate that when people are meaningfully engaged in activities which they enjoy then the likelihood of incidents occurring is reduced.

Services should plan via an assessment of needs and risks how best to support individuals. Early intervention with service users who challenge is important in order to prevent any escalation of behaviours. Individuals with known behavioural management problems should have their needs identified and measures put in place to properly support them and maximise their quality of life; records should include a history of the person's behaviours.

Where behaviour problems are identified services should ensure that staff have access to specialised training. It is important that individual care plans/support plans are properly implemented by staff to ensure that any potential for abusive behaviour is managed appropriately and risks are minimised.

Response

In deciding the appropriate response when an incident has occurred, a risk assessment should be carried out. Factors to consider will include:

- The vulnerability and capacity of the individuals involved
- The nature and extent of the abuse – has the concern caused harm/avoidable harm to the adult at risk?
- Whether it is a 'one off' or a repeat incident
- The impact on the individual and their independence
- The risk of repeated or increasingly serious acts
- Whether the incident amounts to a crime
- The views of the person or their representative

Risk assessment is the process of evaluating these factors to aid decision-making which is **risk management.** A key factor in the deciding how to respond is whether

there has been a harm to the person. This requires careful person centred assessment, and if appropriate, consultation with them and the people close to them. The risk of harm/avoidable harm caused by the incident should be assessed from the point of view of the adult at risk, or their representative. Harm can range from no effect to serious physical injury or emotional distress which damages the person's quality of life.

If it was an isolated incident and has not caused harm to the adult at risk, then there is no requirement to raise a Safeguarding Concern. Nor is there a need to report such incidents through the Provider-Led Concern (Care Concern) process. It is the responsibility of the Provider Manager to ensure that a risk assessment is in place to ensure the immediate safety of all users of the service and to review the support of the individuals involved in the incident.

When to report a Safeguarding Concern in respect of an incident between Adults at Risk

When an incident has caused significant harm to an individual's wellbeing, a Safeguarding Concern must be reported to the Integrated Adults Safeguarding Unit. **Any serious sexual or physical assault will require involvement of the police.**

Where there are ***repeat*** low-level incidents between people using a service, ***or*** when any individual is not satisfied with the way an incident has been managed, then a Safeguarding Concern must be raised.

Where the person causing the harm is also an adult at risk, agencies must be careful not to overlook their duty of care to them. A reassessment of need must be carried out and the care or support plan should ensure that safeguards are in place to prevent repeat incidents.

6. Responding to concerns about nutrition and hydration

Although there is no doubt that many care services provide people with well-balanced meals and the support they need to enjoy their food, it is also known that some people in care services and in the community are failing to thrive because of poor nutrition and hydration with serious consequences. The provision of poor nutritional care within care homes, hospitals and a person's own home has been frequently highlighted in recent years. 37% of those admitted to care homes and 45% of those admitted to nursing homes are malnourished.

Surveys of older people admitted to hospital suggest around a third are dehydrated and a fifth have developed acute kidney injury. Causes of insufficient fluid intake in Care Home residents are mainly reduced sense of thirst, low mood, functional dependence and frailty, cognitive impairment, fear of incontinence, inadequate staffing levels and inadequate systems to monitor and promote intake.

Chronic dehydration is associated with risk of pressure ulcers, constipation, urinary infections and incontinence, kidney disease including acute kidney injury, heart disease, low blood pressure, poorly controlled diabetes, cognitive impairment including delirium, falls and poor oral health, heightening risk of pneumonia. This results in premature mortality, longer inpatient stays and more costly and complex health and social care needs.

For social care staff, only a basic knowledge of nutritional care is necessary in order to tackle malnutrition. Services need to ensure that people at risk are routinely screened and have access to a choice of food that:

- Is adequate in amount and of good quality
- Is well prepared in a safe environment
- Meets any specific dietary, cultural and religious requirements
- Is provided in an environment conducive to eating

Malnutrition can be caused or worsened by conditions relating to older age, so a diet rich in essential nutrients is vital to ensure the right nutritional care is provided.

It is important to ensure that drinks and fresh water are freely available and that people are given the time, help and encouragement they need to eat and drink.

Nutritional Screening and Care Planning

Routine nutritional screening (e.g. MUST screening) should be carried out on admission to services and at regular intervals. Any concerns highlighted must be acted upon and timely referrals made to community health professionals. Daily food and fluid intake must be recorded for those who identified at risk.

There is a need to ensure that people are given the time, help and encouragement they need to take the food and drink provided. Care plans should reflect each individual's nutritional needs. Personal aids, special diets, food and fluid consistencies, special equipment and how individuals need to be seated should all be included in the care plan.

Good practice indicates that staff are trained in the benefits of good nutrition and hydration. Staff should be trained in special dietary requirements, including people with diabetes, dementia and chronic illness, those with wounds or with swallowing difficulties and specifically in the particular dietary requirements of their service users.

A person's nutritional care requirements should include support to maintain oral hygiene and checks on the condition of mouth, teeth and dentures.

When to report a Safeguarding Concern about poor nutrition and hydration

There is a need to distinguish between concerns about the ***quality*** of care provided and care that is ***neglectful***. For example, where a person is not given a meal or drink or is not provided with support to eat or drink and this happens just once then it is not necessary to raise a safeguarding concern. The service provider should refer to the Provider-Led Concern process **(See Section 10 of this Guidance).** However, if there is a failure to provide nutrition and hydration on more than one occasion then a safeguarding concern must be reported as this indicates neglectful practice and may have caused harm to the person.

Most people with dementia lose weight in the later stages of the illness and sometimes this is unavoidable, even with good nutritional support. Where a person loses weight and the care plan has been followed, food/fluid charts completed and specialist advice sought, then a Safeguarding Concern will not be required. However, if there is no evidence of monitoring or action taken in relation to weight loss then a Safeguarding Concern must be reported.

The key indicator for raising a safeguarding concern is that the concern caused harm or was put at risk of significant harm

See Easy Guidance for responding to concerns about nutrition and hydration at Appendix 6.

7. Responding to Pressure Ulcers

Pressure ulcers are caused when an area of skin and the tissue below are damaged as a result of being placed under continuous pressure sufficient to impair blood supply. Typically, they occur in a person confined to bed or a chair due to illness or frailty and as a result are sometimes referred to as 'bedsores' or 'pressure sores'. Pressure ulcers usually start with skin discolouration, and if untreated, can develop into extensive wounds which can become very deep and infected; in the worst cases they can be life threatening.

People who have difficulty moving and are unable to change position easily while seated or in bed are at risk of developing pressure ulcers. The use of seating or beds which are not specifically designed to provide pressure relief can cause pressure ulcers. As pressure ulcers can arise in a number of ways, interventions for prevention and treatment need to be applicable across a wide range of settings including community and care services.

When an individual develops a pressure ulcer it is important that an assessment of their individual circumstances is undertaken taking into account their medical condition, prognosis, any underlying skin conditions, food and fluid intake and the person's views about their care or treatment. This assessment, together with the

grading of the pressure ulcers, should determine whether a safeguarding concern should be reported.

Healthcare professionals use several grading systems to describe the severity of pressure ulcers. The higher the grade, the more severe the injury to the skin and underlying tissue.

Category 1: Non Blanchable Erythema

Intact skin – in lighter skin tones, this presents as non-blanchable redness of a localised area usually over a bony prominence. Darkly pigmented skin may not have visible blanching, but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Category 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).

Category 2: Partial Thickness Skin Loss

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister or as a shiny or dry shallow ulcer, without slough or bruising. This category should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

Category 3: Full Thickness Skin Loss

Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough or necrosis may be present. May include undermining and tunnelling. The depth of a Category 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and Category 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category 3 pressure ulcers. Bone/tendon is not visible or directly palpable.

Category 4: Full Thickness Tissue Loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling. The depth of a Category 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category 4 ulcers can extend into muscle and/or supporting structures (e.g. fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Prevention

Pressure ulcers can occur in any environment and with appropriate management and care can be avoided in most cases.

Where a person is identified as being at risk of developing skin problems because they have difficulty moving or changing position, it is important to evaluate their clinical condition and carry out a pressure ulcer risk assessment using a recognised tool (for example, the Waterlow assessment tool) and the results documented in the person's care records. Any identified need should be recorded in the care plan with the required actions. Risk assessment should be ongoing and is the responsibility of the registered health care professionals working with the person.

Prevention Checklist:

- All staff delivering care receive training on how to prevent pressure ulcers and how to identify the early stages
- All service users receiving care are assessed on the risk of developing pressure ulcers using an appropriate risk assessment took such as Waterlow, Braden or Walsall.
- All service users receiving care are assessed for their nutritional needs using an appropriate risk assessment such as MUST nutritional screening tool
- All service users at risk of developing pressure ulcers are assessed for appropriate pressure relieving equipment and it is provided promptly
- All service users receiving care have a manual handling assessment undertaken
- Key people caring for service users either within hospital, community, care homes or domiciliary care must be sufficiently trained in pressure areas care to identify when a pressure area is developing/deteriorating
- Timely referrals for those needing prompt support are made to community health professionals
- All service users receiving care have a body map completed to identify and monitor any pressure ulcers
- Organisations must regularly review the care provided to service users to manager pressure ulcer care and develop risk management and action plans

When present, pressure ulcers require monitoring and appropriate treatment in order to prevent unnecessary pain and suffering for the person concerned.

Organisations should follow their local and national guidance on prevention and management of pressure ulcers.

When to report a Safeguarding Concern about pressure area care

The Safeguarding Adults Protocol: Pressure Ulcers and Raising a Safeguarding Concern Guidance, March 2024 includes guidance on when it is appropriate or necessary to raise a safeguarding concern in relation to pressure ulcers. The guidance includes an adult safeguarding decision guide, body map and pro-forma to assist practitioners. The full guidance document can be accessed via the following link:

Safeguarding Adults Protocol: pressure ulcers and raising a safeguarding concern

8. Missed Care Home Visits

If a Home Care agency misses a home visit and harm occurs to the person then a Safeguarding Concern must be reported.

Where a visit is missed on one occasion and no harm has occurred there is no need to raise a Safeguarding Concern. However, missed visits that do not cause harm to the person's health and wellbeing still need to be addressed. A discussion needs to takes place between the person involved, or their representative, a manager from the care agency and the social worker, so that the agency can respond and take action to ensure that this does not happen again. The process of resolving the problems should be recorded.

Repeat missed visits to an individual, whether or not this causes harm, must be raised as a safeguarding concern as this indicates neglectful care which may leads to harm.

9. Responding to Medication Errors

The Care Quality Commission (CQC) sets essential standards of quality and safety for regulating health and social care providers including standards for the management of medicines. Therefore, health and social care providers must have clear procedures in place regarding the management of medicines.

You should have a robust medicines policy which includes related safety incidents, all 'near misses' and incidents that do not cause any harm. The policy should cover:

- whether to notify CQC
- which medicines related safeguarding incidents to report under local safeguarding processes
- how to report the incident to the person, their family or carers
- how to handle referrals to regulators and other agencies, such as NMC (CQC)

What is a medication error?

While most medicines are used in a safe and effective way, medication errors are one of the most common causes of patient harm, accounting for 20-30% of

reportable incidents in NHS organisations (CQC). A medicines error is any patient safety incident, where there has been an error while: prescribing, preparing, dispensing, administering, monitoring, providing advice on medicines, storage, regardless of whether it has had a significant impact. Errors may result in an incident, an adverse event or a 'near miss'.

Examples of scenarios which could be raised as safeguarding incident or provider led concern:

Preparation and administration errors:

- Medicines being given covertly without following correct procedure, i.e. assessing capacity, holding a best interest meeting and documenting the joint decision.
- Essential medicines not being given and no valid reason recorded.
- Medicines not being reviewed resulting in medicine being continued unnecessarily with risk of adverse effects.
- Side effects of medicines not being identified or reported.
- Removing responsibility from people who could manage their own medicines with support.
- Medicines given at wrong time, e.g. paracetamol less than four hours apart, Parkinson drugs not given at specified times.
- Resident administered the wrong medication, dose, route.
- Resident administered an out of date medicine.
- Medication administered to the wrong patient.
- Medication incorrectly prepared.
- Incorrect infusion rate.
- Administration of medication recorded incorrectly or not recorded.

Monitoring errors:

- Patient known to be allergic to medication but the medication was prescribed and/or dispensed and/or administered.
- Failure to provide the patient with correct information regarding their medication, e.g. when to take, what it is for, side effects.
- Failure to monitor therapeutic levels.
- Failure to monitor resident who is undertaking self-medication.
- Failure to react appropriately to signs of ill health, pain or requests for help due to being unwell associated with medication administration.

Other errors may include:

- Poor or inadequate communication.
- Poor, inadequate or incorrect recording/documentation.

- Inappropriate or inadequate storage or disposal of medicines.
- Inappropriate administration of medication to chemically manage a resident's behaviour that has not been prescribed or giving additional doses to sedate resident.
- Deviation from local policy and guidelines relating to medicines management.

Potential areas of high risk:

- Processes which involve the use of appliances which require special administration techniques such as catheters, oxygen and enteral feeding tubes.
- Administration of controlled drug preparations, in particular combinations of immediate release and slow release, e.g. different preparations of morphine Sevredol® and MST Continus®.
- Handling of medicines with similar names e.g. risperidone and ropinirole, amiloride and amlodipine, hydroxyzine and hydralazine, Maxidex® and Maxitrol®, promethazine and promazine.
- Anticoagulant dosing
- Insulin dosing

It is therefore essential that all organisations providing care have clear procedures on managing medicines and provide appropriate training and competency checks for relevant staff.

Where a medicines management error occurs, or where a person has not been given their medication as intended by the prescriber, the manager needs to consider how to respond to the incident; the response will depend on whether the error has caused harm to the person. If in doubt, the manager should seek immediate advice from a qualified health professional. If no harm occurred or risk of harm, then the manager should report the incident through the Provider-led concern and enquiry process. **Refer to Section 10 of this guidance.**

When to report a Safeguarding Concern about a Medication Error

A safeguarding issue in relation to managing medicines could include; the deliberate withholding of a medicine(s) without a valid reason, the incorrect use of medicine(s) for reasons other than the benefit of a resident, deliberate attempt to harm through use of a medicine(s), or accidental harm caused by incorrect administration or a medication error. (NICE SC1)

Where a medicines management error occurs, or where a person has not been given their medication as intended by the prescriber, and this has a significant impact on the person then a Safeguarding Concern must be raised.

A ***repeat*** medication error, even if there has been no significant impact, must be reported as a Safeguarding Concern as repeat incidents may indicate that safe systems are not in place.

Report incidents related to controlled drugs (including loss or theft) to your local NHS Controlled Drugs Accountable Officer.

10.0 Guidance for initiating Provider-Led Concerns (Formerly Care Concerns) when poor practice is identified

The Safeguarding Adults Board has recognised that there will be occasions when it is appropriate for provider agencies to respond to incidents of poor practice, without the need to initiate multi-agency Safeguarding Procedures. Poor practice will always require a response because if not challenged, it can result in a further deterioration in standards leading to longer term difficulties; in many instances the provider manager will be the appropriate person to take remedial action. This guidance outlines those circumstances in which the provider service should take responsibility for responding to incidents of poor practice without the need to raise a Safeguarding Concern.

Responding to incidents in Provider Services

On receiving information about an incident the provider manager should determine whether it is appropriate for the concern to be dealt with under Safeguarding Procedures as a Safeguarding Concern, or as a provider led concern about poor care. See Flow Chart at Appendix 9. In making the decision the Manager should consider the nature and seriousness of the incident/concern by reference to the examples set out at Appendix 11.

Provider managers will be expected to identify and investigate low level concerns that is, situations in which the standard of care provided has fallen short of that expected but has not caused harm to the person.

In circumstances where no harm has occurred, the Provider should complete the **Provider-Led Concern Form** and email it securely to Integrated Adults Safeguarding Unit at careconcerns@halton.gov.uk . The provider will then initiate an enquiry following guidance from the Integrated Adult Safeguarding Unit.

Provider-Led Enquiries

The main purpose of identifying an incident of poor care is to rectify any deficiency immediately, understanding why care was compromised and put in place measures to ensure that the risk of any repetition is minimised.

To support this process and to ensure that there is a full enquiry and any lessons learnt, the provider service should complete the **Provider Led Enquiry Report** which must then be returned by email to Integrated Adults Safeguarding Unit at: careconcerns@halton.gov.uk within **14 days** of reporting the Provider-Led Concern.

It will be the responsibility of the provider service to complete this document and ensure that it is forwarded to the email address on the form using a secure email system within the timescale outlines. If there is likely to be a delay please contact the Integrated Adults Safeguarding Unit to discuss this on **0151 511 8555**

If the Provider Led Enquiry is not shared within the 14 days of Halton receiving the Notification, a Safeguarding Concern will be raised. This will lead to a Section 42 Enquiry to assure the Local Authority that risks have been mitigated, MSP has been adhered to and the Adult at Risk feels safer.

Monitoring Arrangements

All Provider-Led Enquiry Reports will be subject to quality assurance and there will be arrangements to ensure that any lessons learnt are shared across providers through the Provider Forum, Safeguarding Champions Forum and HSAB

NHS Providers

Low level incidents in NHS services require a different response; Health Trusts are statutory organisations and have their own governance arrangements in relation to patient safety, dignity and respect. There is no expectation that NHS Trusts will report low level incidents through the Provider-Led Concern process, they should follow their own procedures.

When to report a Safeguarding Concern (Provider Services)

Some incidents/issues should **not** be investigated by the provider and should always be referred as a Safeguarding Concern for a multi-agency enquiry. These include:

- Physical assault
- Sexual assault
- Financial abuse
- Wilful neglect
- Any act/omission which has resulted in physical injury or harm
- Any allegation of harm that constitutes a criminal offence

A Safeguarding Concern should be raised when there are ***repeat*** low level concerns as it is recognised that in some cases it is the ***repetition*** of minor actions or omissions that collectively will amount to abuse.

Determining whether or not abuse has taken place is not always a straightforward matter, particularly when the concerns relate to neglect. A judgement will be required about whether an act or an act of omission has caused harm to the person or they were at risk of avoidable harm.

If you are unsure whether a particular incident/issue should be addressed by a Provider-Led Concern or a Safeguarding Concern, please contact the Integrated Adults Safeguarding Unit for advice on **0151 511 8555.**

References:

Falls: assessment and prevention of falls in older people *NICE Clinical Guideline 161 Issued: June 2013* www.guidance.nice.org.uk/cg161

Managing Falls in Care Homes *Bexley Primary Care NHS Trust*

South West Safeguarding Adults Thresholds Guidance March 2011 *Association of Directors of Adult Social Services (ADASS) Safeguarding Adults Network* www.adass.org.uk

Care Act 2014 Care and Support Statutory Guidance on Adult Safeguarding https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

Nutritional Care and Older People *Social Care Institute for Excellence (SCIE) 2009* Available on SCIE website at: http://www.scie.org.uk/publications/ataglance/ataglance03.asp

Close to Home Inquiry: an inquiry into older people and human rights in home care *Equality and Human Rights Commission (EHRC) 2011.* Available on EHRC website at:

www.equalityhumanrights.com/homecareinquiry

Pressure ulcers: prevention and management of pressure ulcers *NICE Clinical Guideline 179 Issued: April 2014.* Available on NICE website at: http://www.nice.org.uk/guidance/cg179/chapter/introduction

Managing medicines in Care Homes NICE Guidelines (SC1) Issued March 2014 Available on NICE website at:

https://www.nice.org.uk/guidance/sc1

Safeguarding Adults Policy 2024

Safeguarding Adults in Halton: Procedures and Good Practice Guidance 2024

Reporting medicine-related incidents CQC Guidance for Providers https://www.cqc.org.uk/guidance-providers/adult-social-care/reporting-medicine-related-incidents

Care homes - Safeguarding and medicines PrescQIPP https://www.prescqipp.info/umbraco/surface/authorisedmediasurface/index?url=%2fmedia%2f1190%2fb172i-care-homes-safeguarding-and-medicines-20.pdf

Appendix 1: Criteria for raising a Safeguarding Concern in respect of a Fall

Easy Guidance

When should a fall be reported through Safeguarding Procedures?

- Where a person sustains an injury due to a fall and there is a concern that an appropriate risk assessment was not in place or was not followed, this must be reported as a Safeguarding Concern. The key factor is that the person has experienced ***avoidable*** harm.

- Where a person has sustained an injury which has resulted in a change in function and appropriate medical attention has ***not*** been sought, this must be reported as a Safeguarding Concern.

- Where a person has an unexplained injury, other than a very minor injury, this must be reported as a Safeguarding Concern

When don't I need to report a Safeguarding Concern?

- A concern does not need to be raised when a person is found on the floor, is not injured and appropriate risk assessment is in place and has been followed

- A Concern does not need to be reported when a fall is witnessed and appropriate risk assessment is in place and has been followed

- A Safeguarding Concern does not need to be reported when the person has capacity to understand what happened and states that they fell

Note: The criteria for safeguarding is met when the fall has caused harm to the person and there is a concern about possible abuse or neglect *by another person* (or the person themselves in cases of self-neglect). Accidental falls do ***not*** meet the criteria for safeguarding when a risk assessment is in place and has been followed.

This guidance is intended to offer guidance to managers in making decisions but it is acknowledged that at times there may be incidents where decision making is not straightforward and professional judgement is required. In all cases, ensure that the reasons for the decision are recorded.

If in doubt, raise a safeguarding concern. The professional within the Integrated Adult Safeguarding Unit will then decide how to proceed.

Appendix 2 - Triggers for Falls Risk – points to consider

Trigger	
Memory loss/confusion/behaviour/diagnosed/psychiatry	
Eyes/Glasses/Eye Test	
Communication of Needs	
Motivation happy/sad	
Weight Loss	
Painful Joints	
Footwear/Slippers	
Toenails/Feet	
Continence/Toilet Facilities	
Tremor?	
Posture	
Muscle weakness/Frailty	
Ears/Hearing Aid/Dizziness	
Sleep Patterns	

Previous Falls History

Also consider:

- Diagnosis
- Medications
- Bone Health
- Illness/Infections
- Environment
- Walking Aid? Appropriate/Used

Patient Details …….. **Review Date …….**

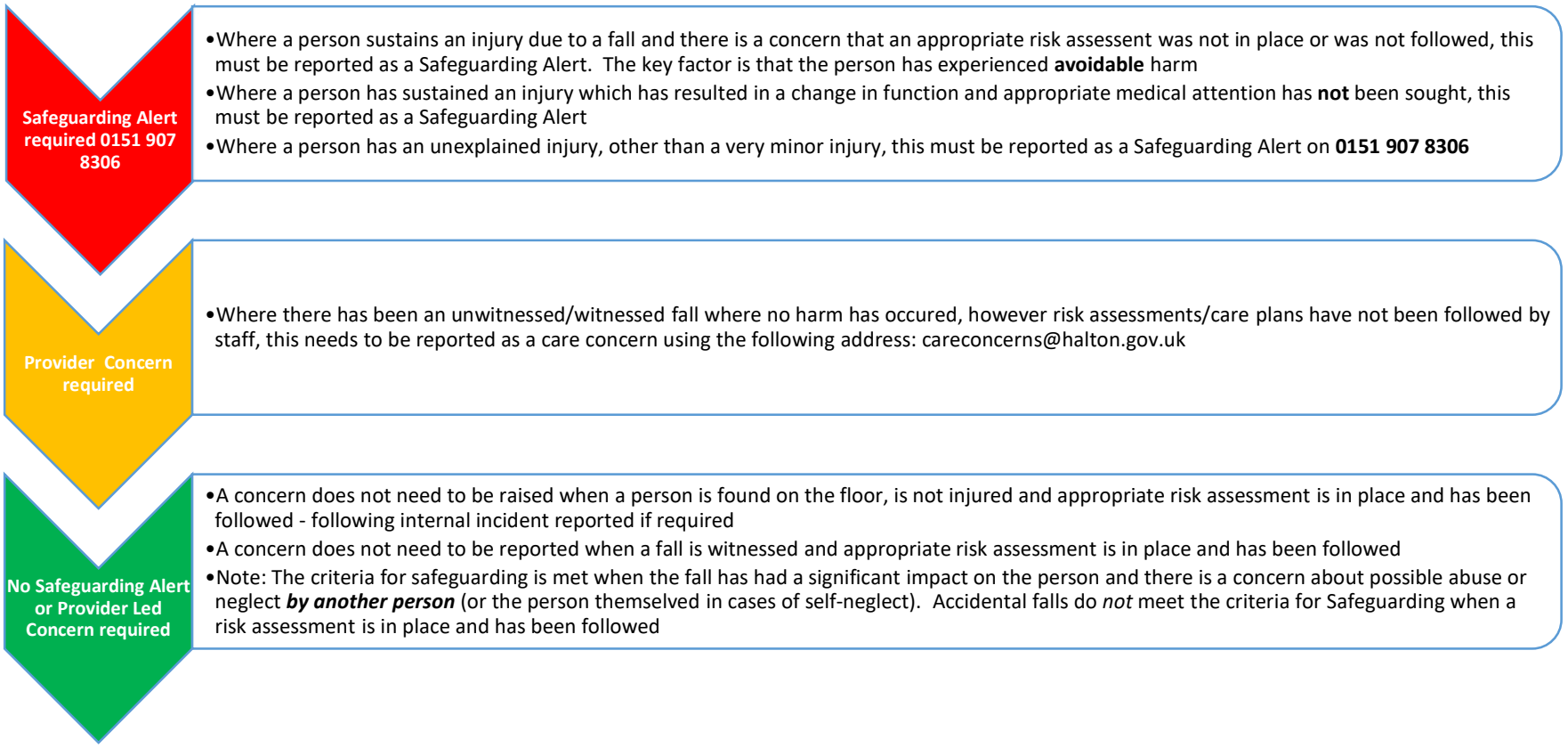
Date ……

Triggers for Falls Risk (2)

Actions Completed:
Actions To Do:
Things to Consider:
Statement regarding Patients Future Risks:

Falls Guidance and Safeguarding

Where a person has sustained an injury which has resulted in a change in function and appropriate medical attention has not been sought, this must be reported as a Safeguarding Concern. If in doubt, raise a Safeguarding Concern and the professions within the Integrated Adult Safeguarding Unit will then decide how to proceed.



Appendix 3: Criteria for raising a Safeguarding Concern in respect of incidents between Adults at Risk

Easy Guidance

When should an incident be reported through safeguarding procedures?

- When any person has been harmed during an incident complete the online Safeguarding Concern form at: https://adult.haltonsafeguarding.co.uk/what-is-abuse/ or 0151 907 8306

  Any serious sexual or physical assault will require the involvement of police

- Where there are ***repeat*** low level incidents (incidents where no harm has been caused), ***or*** when any individual is not satisfied with the way an incident has been managed by the provider, then a Safeguarding Concern must be raised

- Where the person causing the harm is also an adult at risk, agencies must be careful to ensure that they receive support. A reassessment of need must be carried out and the care or support plan should ensure that safeguards are in place to prevent repeat incidents

When don't I need to report a Safeguarding Concern?

- When an incident was a 'one-off' and there has been no harm on any individual (from ***their*** point of view) it is not necessary to raise a Safeguarding Concern

- It is not necessary to report such incidents through the Provider-led enquiry (Care Concern) process ***unless*** there was some failing on the part of the service

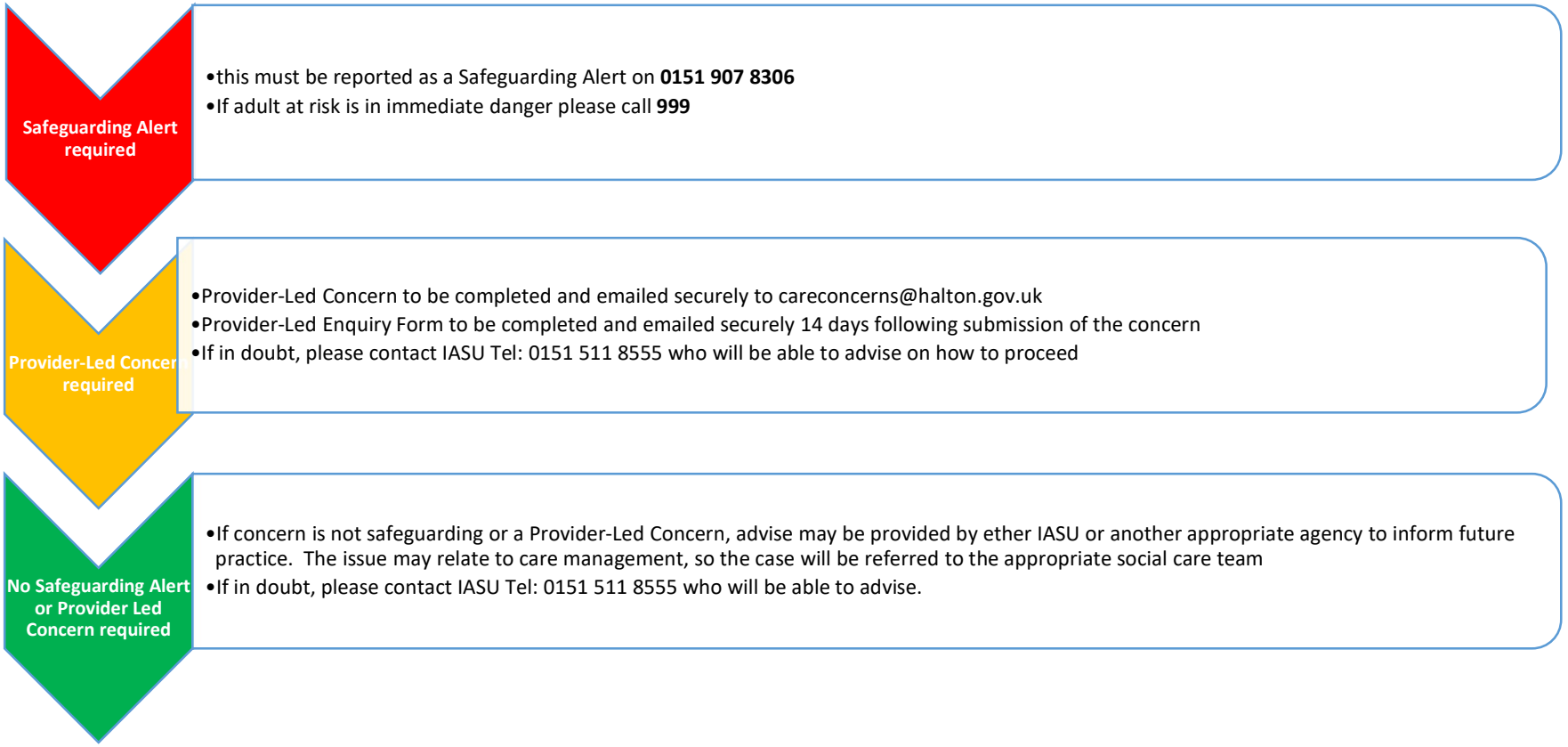
- In the circumstances above it is the responsibility of the provider manager to ensure that a risk assessment is in place to ensure the immediate safety of ***all*** users of the service and to review the support of the individuals involved in the incident

This document is intended to offer guidance to managers in making decisions but it is acknowledged that at rimes there may be incidents where decision-making is not straightforward and professional judgement is required. In all cases ensure that the reasons for the decision are recorded. If in doubt, contact the Integrated Adult Safeguarding Unit Tel: 0151 511 8555 who will advise on how to proceed. If unsure or out of house, please make safeguarding concern referral.

Appendix 4: Tool for responding to incidents between Adults at Risk

Criteria Informing Reporting	Criteria Informing the Managers Decision *(Note: all actions must be recorded)*
Low level concerns:	
Where there are sufficient concerns to take action but there is no evidence of harm (see below) All staff are responsible and accountable and must ensure that their concerns are recorded, brought to the notice of a senior manager in the service and action agreed. Any action must be followed up and recorded in the person's plan	• Action taken by provider • Care Plan/Action Plan/Support Plan • Review Meeting – Care Plan/Action Plan/Support Plan
Safeguarding Concerns:	
Where harm has occurred or an unacceptable degree of risk is present. If in doubt apply the harm definition i.e. ill treatment (including sexual abuse and forms of ill treatment that are not physical) that result in the impairment of or an avoidable deterioration in physical or mental health, and the impairment of physical, emotional, social or behavioural development. Complete the online Safeguarding Referral Form at: https://adult.haltonsafeguarding.co.uk/what-is-abuse/ Or call the Integrated Adult Safeguarding Unit for advice **Tel: 0151 511 8555**	• Action taken by provider • Care Plan/Action Plan/Support Plan • Review meeting – Care Plan/Action Plan/Support Plan • Safeguarding Adults Concern contact Integrated Adult Safeguarding Unit (IASU) • Strategy Discussion – multi-agency response • Strategy Meeting – multi-agency enquiry • Safeguarding Plan agreed • Safeguarding Plan reviewed within 6 months

Note: This tool is intended to support good practice in ensuring that abuse by another service user is seen as just as harmful as that perpetrated by anyone else. It should be used to support the decision-making process but discretion and sound judgements will always be required of Managers and in some cases more than one response may be called for. If in doubt, report a Safeguarding Concern to the Integrated Adults Safeguarding Unit (IASU).


Safeguarding Alert required
•this must be reported as a Safeguarding Alert on **0151 907 8306**
•If adult at risk is in immediate danger please call **999**
Provider-Led Concern required
•Provider-Led Concern to be completed and emailed securely to careconcerns@halton.gov.uk
•Provider-Led Enquiry Form to be completed and emailed securely 14 days following submission of the concern
•If in doubt, please contact IASU Tel: 0151 511 8555 who will be able to advise on how to proceed
No Safeguarding Alert or Provider Led Concern required
•If concern is not safeguarding or a Provider-Led Concern, advise may be provided by ether IASU or another appropriate agency to inform future practice. The issue may relate to care management, so the case will be referred to the appropriate social care team
•If in doubt, please contact IASU Tel: 0151 511 8555 who will be able to advise.

Appendix 5: Examples – Incidents between Adults at Risk

No.	Incident	Action	Risk of Harm
1	Two men with a learning disability argue and one calls the other an offensive name. They usually get on well and neither shows any distress following the altercation; there are no difficulties between them following the incident. The provider is able to advise and support appropriately	Provider action	Low
2	A similar incident to above involving two women without capacity. Having been sworn at for picking up the wrong handbag, one spits at the other. Neither recalls the specific incident afterwards nor do they show any distress. The provider takes action to keep the women apart and neither family is concerned	Provider action	Medium
3	A man with mental health issues is placed in a supported living house. He has physically assaulted co-residents in a previous placement and in intimidating towards other tenants in his new home, but there have not been any incidents	Safeguarding Concern refer to Integrated Adult Safeguarding Unit (IASU)	Medium/potential for High
4	An older man without capacity has started to make sexually inappropriate remarks to other service users and staff are concerned that this is a repetition of earlier behaviour patterns which led to a serious incident	Safeguarding Concern refer to Integrated Adult Safeguarding Unit (IASU)	Medium/potential for High
5	An older man without capacity physically attacks another resident causing him to fall and require hospital admission. Evidence of Intent is clear	Safeguarding Concern refer to Integrated Adult Safeguarding Unit (IASU)	High

Appendix 6: Nutrition and Hydration – Criteria for raising a Safeguarding Concern

Easy Guidance

When should a Safeguarding Concern be reported?

- If there is a failure to provide nutrition and hydration to an adult at risk on more than one occasion, then a Safeguarding Concern must be raised as this indicates neglectful practice which is likely to have caused harm.
- Where a person loses weight or is showing signs of dehydration and a care plan is not in place or has not been followed, food/fluid charts have not been completed and specialist advice has not been sought, then a Safeguarding Concern must be reported.
- The key indicator for raising a Safeguarding Concern is that harm has occurred (or is likely to occur) and that the harm was ***avoidable***.

When don't I need to report a Safeguarding Concern?

- Where a person is not given a meal or drink, or is not provided with support to eat or drink and this happens just once then it is not necessary to make a Safeguarding Concern. This is because a one-off incident is not likely to have caused harm. The service provider should refer through the Provider-Led Concern process (See Section 10 of this guidance).

- Where a person loses weight or is dehydrated and the care plan ***has*** been followed, food/fluid charts completed and specialist advice sought, then a Safeguarding Concern need not be raised.

This document is intended to offer guidance to managers making decisions but it is acknowledged that at times there may be incidents where decision-making is not straightforward and professional judgement is required. In all cases ensure that the reasons for the decision are recorded.

If in doubt contact the Integrated Adult Safeguarding Unit (IASU) Tel: 0151 511 8555 who will advise on how to proceed

Appendix 7 Pressure Areas – Criteria for raising a Safeguarding Concern

Easy Guidance

When should a Safeguarding Concern be made?

- A Safeguarding Concern should be reported when a failure to provide adequate care has resulted in a person developing a pressure ulcer.
- A person identified as being at risk develops a pressure ulcer and a care plan is not in place or has not been followed
- A person identified as being at risk developed a pressure ulcer does not have appropriate equipment provided in a timely way or staff are not trained in using equipment
- A person identified as being at risk develops a pressure ulcer and repositioning charts are not used or are not completed
- A person identified as being at risk develops a pressure ulcer and specialist advice has not been sought

The key issue is whether the development of a pressure ulcer was *avoidable, if so, a Safeguarding Concern must be reported*

When don't I need to report a Safeguarding Concern?

- A person has developed a pressure ulcer and a care plan is in place and has been followed, turning charts have been completed, necessary equipment is in place and staff are appropriately trained

This document is intended to offer guidance to managers in making decisions but it is acknowledged that at times there may be incidents where decision-making is not straightforward and professional judgement is required. In all cases ensure that the reasons for the decisions are recorded.

If in doubt contact the Integrated Adult Safeguarding Unit (IASU) Tel: 0151 511 8555 who will advise on how to proceed

Appendix 8: Medication Errors – Criteria for Reporting a Safeguarding Concern

Easy Guidance

When should a Safeguarding Concern be reported?

- A safeguarding issue in relation to managing medicines could include the deliberate withholding of medication with no medical reason; the incorrect use of medication for reasons other than the benefit of the person; a deliberate attempt to harm through use of a medicine; unintentional harm due to incorrect medication or dose being given; unintentional harm due to failure to administer prescribed medication

- Where a medicines management error results in harm to an adult at risk then a Safeguarding Concern must be reported

- Where a person has not been given their medication as intended by the prescriber and this results in harm then a Safeguarding Concern must be raised

- A ***repeat*** medication error, even if the person has not been harmed, must be reported as a Safeguarding Concern as repeat incidents may indicate that safe systems are not in place.

When don't I need to report a Safeguarding Concern?

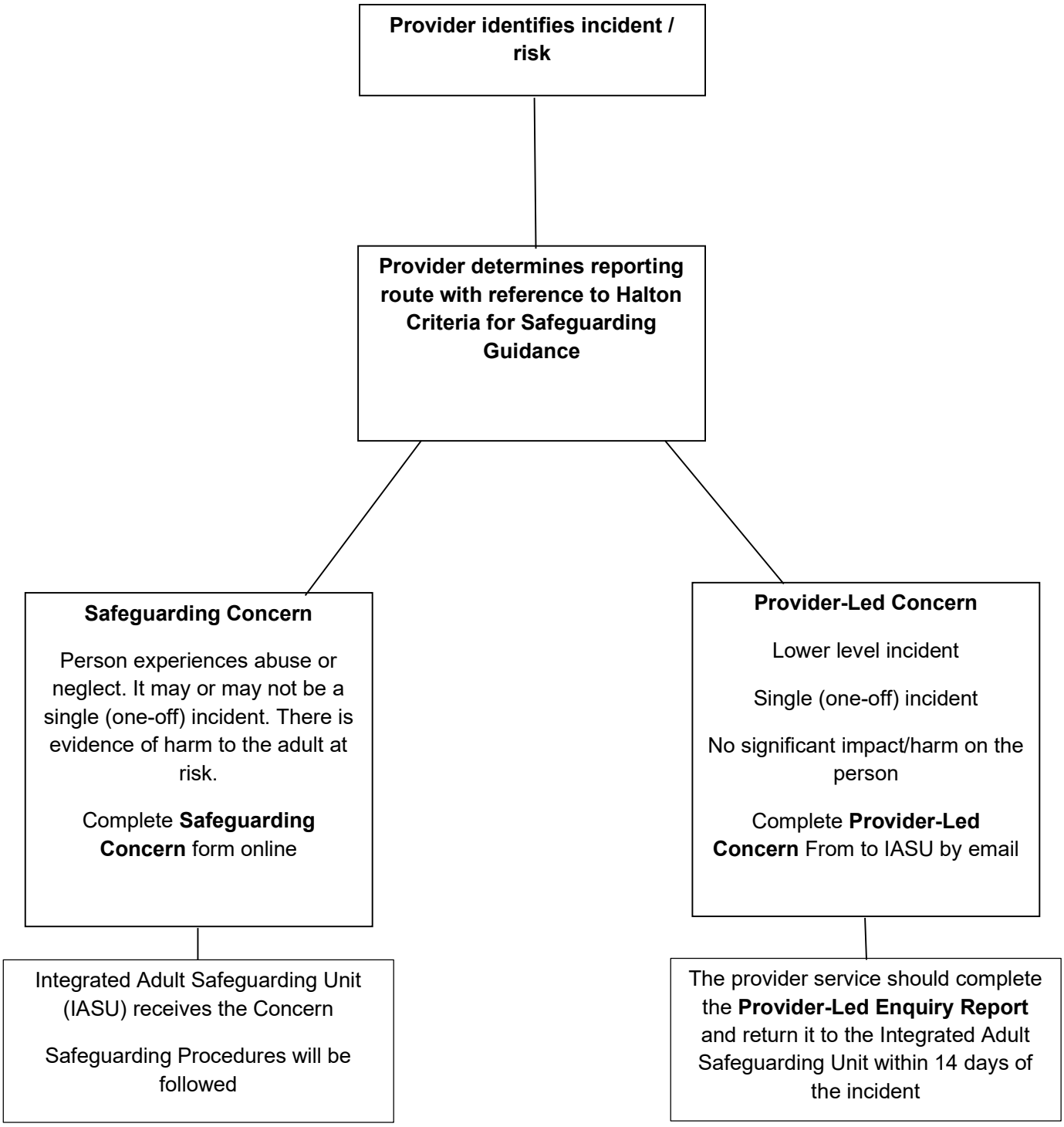
- Where a medicines management erroris made, no harm occurs and it is a 'one-off' incident, the Manager should report the incident through the Provider-Led Concern (formerly Care Concern) process. Refer to Section 10 of this guidance.

- Where a person has not been given their medication as intended by the prescriber, no harm occurs and it is a 'one-off' incident, the Manager should report the incident through the Provider-Led Concern process. Refer to Section 10 of this guidance.

This document is intended to offer guidance to managers in making decisions but it is acknowledged that at times there may be incidents where decision making is not straightforward and professional judgement is required. In all cases ensure that the reasons for the decision are recorded.

If in doubt contact the Integrated Adult Safeguarding Unit (IASU) Tel: 0151 511 8555 who will advise on how to proceed

Appendix 9: Safeguarding Concern/Provider Led Concern



Appendix 10 Guidance for initiating Provider-Led Concerns (Formerly Care Concerns)

Easy Guidance

- Financial, physical or sexual abuse **are always** Safeguarding Concerns and must be reported to the Integrated Adult Safeguarding Unit (IASU). The Provider must not commence an enquiry as a Police enquiry may be required.

- Where a service user has been a victim of abuse by another service user, and there are sufficient concerns to take action but there is no evidence that harm has occurred, please consult the guidance on responding to incidents between service users at Section 10 of this guidance. **Low level incidents between service users (incidents which have not resulted in any harm can be managed by the Provider, without the need to report as a Provider-Led Concern to Integrated Adult Safeguarding Unit.** More serious incidents between service users which result in a service user being harmed, and/or the person or their representative is not satisfied with the way the incident has been managed, must be reported as Safeguarding Concerns. **(*Repeat low level incidents of abuse of a service user by another must be reported as Safeguarding Concerns).***

- Report through the Provider-Led Concern process when you identify an incident in which the care provided by ***your*** service has been compromised but the incident has not caused harm to the person. (Complete a **Provider-Led Concern Form** and forward to the Integrated Adult Safeguarding Unit. Complete a **Provider Enquiry Report** within **14 days** and forward to careconcerns@halton.gov.uk A ***repeat*** incident of compromised care should be reported as a Safeguarding Concern.

- **You cannot report an issue about/on behalf of another Agency** through the Provider-Led Concern process; the key issue is that the agency themselves has recognised poor practice and is taking action

- Not every incident involving a service user requires a Provider-Led Concern ***or*** a Safeguarding Concern to be reported. **You do not need to report** accidents, illness or any natural events through the Provider-Led process.

- You do not need to raise a Provider-Led Concern or a Safeguarding Concern when a person's own behaviour has caused harm to him/herself and risk assessments have been followed

This document is intended to offer guidance to managers in making decisions but it is acknowledged that at times there may be incidents where decision-

making is not straightforward and professional judgement is required. In all cases ensure that the reasons for the decision are recorded.

If in doubt contact the Integrated Adult Safeguarding Unit Tel: 0151 511 8555 who will advise on how to proceed.

Appendix 11: Guidance for initiating Provider-Led Concerns – Examples

The following guidance may be used to assist in distinguishing between poor practice i.e. failure to meet a service user's care needs, which should be managed by a provider agency and addressed as a Provider-Led Concern and abuse which should trigger the reporting of a Safeguarding Concern.

The following table illustrates **examples** of circumstances which can be managed by reporting a Provider-Led Concern and those which should be reported as a Safeguarding Concern; please note this is ***not*** an exhaustive list.

Area of concern	*Provider-led Concern* Examples of poor practice which requires action by a provider organisation e.g. care home or domiciliary care manager	*Safeguarding Concern* Examples of possible abuse which requires reporting as such, and the instigation of Safeguarding procedures
1. Failure to provide assistance with food/drink	Person does not receive necessary help to have a drink/meal. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem; emergency occurring elsewhere in the home; dealt with under staff disciplinary procedures - would not be reported as a Safeguarding Concern	Person does not receive necessary help to have drink/meal and this is a recurring event, or is happening to more than one person. This constitutes neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding enquiry. Harm: malnutrition; dehydration; constipation; tissue viability problems
2. Failure to provide assistance to maintain continence	Person does not receive help to get to toilet to maintain continence or have appropriate assistance such as changed incontinence pads. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem; emergency occurring elsewhere in the home; dealt with under staff disciplinary procedures – would not be reported as a Safeguarding Concern	Person does not receive necessary help to get to toilet to maintain continence and this is a recurring event, or is happening to more than one person – neglectful practice, may be evidence of institutional abuse and would prompt reporting of a Safeguarding Concern. Harm: pain; constipation; loss of dignity; humiliation; skin problems

3. Failure to seek assessment re: pressure area management	Person known to be susceptible to pressure ulcers has not been formerly assessed with respect to pressure area management but not discernible harm has arisen. Complete Provider-Led Concern Form. This may need to be dealt with under disciplinary procedures.	Person is frail and has been admitted without appropriate risk assessment in respect of pressure area management (or plan not followed). Care provided with no reference to specialist advice re: diet, care or equipment. Pressure damage occurs. Neglectful practice; breach of regulations and contract; possible institutional abuse. Safeguarding Concern should be reported. Harm: avoidable tissue viability problems
4. Medication not administered	Person does not receive medication as prescribed on one occasion but no harm occurs. Internal enquiry should be undertaken, possible disciplinary action depending on severity of situation including type of medication	Person does not receive medication as a 'one off' but the medicine is a Controlled Drug and/or time critical, or it is a recurring event, or it is happening to more than one person. Neglectful practice; breach of professional code of conduct if nursing care provided. Dependent on degree of harm, possible criminal offence. Report as a Safeguarding Concern.
5. Moving and Handling procedures not followed	Appropriate moving and handling procedures not followed but person does not experience harm. Provider acknowledges departure from procedures and inappropriate practice and deals with this appropriately under disciplinary procedures (to the satisfaction of person involved).	One or more people experience harm through failure to follow correct moving and handling procedures, or frequent failure to follow moving & handling procedures make this likely to happen. Neglectful practice – reported as a Safeguarding Concern. Harm: injuries such as falls and fractures; skin damage; lack of dignity; loss of confidence for the person

6. Failure to provide support to maintain mobility	Person not given recommended assistance to maintain mobility on one occasion	Recurring event, or is happening to more than one person, resulting in reduced mobility. Harm: loss of mobility; confidence and independence
7. Failure to provide medical care	An adult at risk is in pain or otherwise in need of **medical care** such as dental; optical; audiology assessment; foot care or therapy, does not on one occasion receive required medical attention is a timely manner	An adult at risk is provided with an evidently inferior medical service or no service. Harm: pain; distress; deterioration in health
8. Inappropriate comments from staff	Person is spoken to in a rude; insulting; humiliating or other inappropriate way by a member of staff. They are not distressed and this is an isolated incident. Provider takes appropriate action, to the satisfaction of the person involved	Person is frequently spoken to in a rude; insulting; humiliating or other inappropriate way or it happens to more than one person. Regime in the home doesn't respect people's dignity and staff frequently use derogatory terms and are abusive to residents. Regulatory breach – report as a Safeguarding Concern Harm: demoralisation; psychological distress; loss of self esteem
9. Significant need not addressed in Care Plan	Person does not have within their Care Plan/Service Delivery Plan/Treatment Plan a section which addressed a significant assessed need, for example: • Management of behaviour to protect self or others • Liquid diet because of swallowing difficulty • Cot sides to prevent falls and injuries but no harm occurs	Failure to specify in a patient/client's plan how a significant need must be met. Inappropriate action or inaction related to this results in harm such as *injury, choking etc.* Report as a Safeguarding Concern.

10. Care Plan not followed	Person's needs are specified in Treatment or Care Plan not followed, need not met as specified but no harm occurs	Failure to address a need specified in a person's plan results in harm. This is especially serious if it is a recurring event or is happening to more than person. Report as a Safeguarding Concern
11. Domiciliary Care Visit missed	Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs. Provider deals with this appropriately through internal enquiry, to the satisfaction of person involved	Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being resulting in harm or serious risk to the person. Report as a Safeguarding Concern.
12. A person who lacks capacity to make decisions regarding their personal safety is missing from a Care Home	Staff become aware immediately that the person is missing and locate the person before they have left the grounds of the Home	The person leaves the grounds of the Home and is found in the community. Report as a Safeguarding Concern. Potential for very serious harm: road accident; physical injury; distress

What should I do if I am unsure?

If after considering this guidance you are still unsure as to whether you need to initiate the safeguarding process then you can discuss it with your Manager or Safeguarding Lead for your organisation; or contact the Integrated Adult Safeguarding Unit Tel: 0151 511 8555.