



Eastern Regional Safeguarding Adults Forum

Adult Safeguarding Best Practice Guidance for Providers of Healthcare in East Anglia and Essex

October 2018



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Foreword

Dear Colleagues,

During its inaugural meeting, the East Anglia and Essex NHS Adult Safeguarding Forum identified that there was a need for clear guidance to help staff make decisions about adult safeguarding within their organisations. The Best Practice Guidance was developed to support practitioners recognise incidents of abuse that must be taken through the safeguarding processes, and differentiate those from incidents that should be case or risk managed, or taken through other routes (complaints, Serious Incident reporting, case management).

The guidance was originally developed through extensive consultation and commitment, and officially launched at our Adult Safeguarding Conference March 2016. This has now been reviewed by the original members of the task and finish group, with only a few very minor amendments required. I would like to thank the task and finish group for their ongoing support, expertise, and valuable input into reviewing the guidance.

Since the launch of this guidance, we have received phenomenal feedback in terms of the value of this resource for health and social care providers and practitioners, and within the wider care arena including the voluntary sector. We hope that you continue to find this a helpful resource.



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NB: All providers must continue to manage their serious incidents, which will include some safeguarding incidents, in accordance with their commissioner's guidance and national reporting systems. This document does not replace the Serious Incident policy or governance framework within your organisation but can be considered alongside existing adult safeguarding policies and procedures.

NHS Adult Safeguarding Best Practice Guidance

1. Introduction

The Eastern Regional NHS Adult Safeguarding Group has developed this best practice guidance to provide a set of standards across the region.

This document has been developed using the following as reference:

- The Care Act (2014)
- The Code: Standards of conduct, performance & ethics for nurses and midwives (2015)
- Care Quality Commission – Essential Standards of Quality and Safety (2010)
- Essex Safeguarding Adults Board Thresholds document (2012)
- South West England Safeguarding Adults Thresholds Guidance (March 2011)
- Newcastle Safeguarding Adults Board Threshold Guidance (2011)
- County Durham Inter-Agency Partnership Risk Threshold Tool (2011)
- ADASS North East Safeguarding Thresholds Guidance (2011)
- Bury Safeguarding Adults Multi Agency Thresholds Guidance (2012)
- NHS England Serious Incident Framework (2015)
- NHS Constitution for England (2015)

2. Why do we need a Best Practice document?

The NHS is accountable for delivering safe, high quality care to patients. This duty is underpinned by the NHS Constitution that all providers of NHS services are legally obliged to take account of quality. This means that all care provided must be safe and effective which, in turn, will result in a positive patient experience.

Some people may be unable to defend their rights and protect themselves from abuse or harm. These people may be the most vulnerable and have the greatest dependency on services but be unable to hold those services to account for the quality of care delivered. The NHS has a clear responsibility to ensure that those people receive high quality care and that their human and civil rights are upheld – including the right to be safe.

Increasingly in the field of Adult Safeguarding the term “safeguarding” has become a generic term for many issues involving adults who are at risk of abuse or neglect. More and more frequently, adult safeguarding practitioners are called upon to respond to incidents that would be best managed through quality assurance, complaints or case management procedures. Accordingly this has contributed to a sustained increase in referrals to local social care organisations. At the same time as the increase in referrals, health and social care organisations are affected by budgetary constraints. To reduce the risk of this negatively affecting the adult safeguarding services, it is important that organisations introduce agreed best practice guidance. This will support clarity and consistency in decision making and ensure that resources are targeted effectively to safeguard adults at risk of abuse.

There is often confusion between safeguarding, safety, and being safe. They become merged with inappropriate safeguarding concerns being raised as a

consequence. The impact this has on limited resources and also patients and families involved should not be underestimated.

Safeguarding means 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 (Making Safeguarding Personal). Abuse causes harm or distress and it can include deliberately exploiting the person or committing an act of omission which causes harm or distress to them. There is a perpetrator of abuse and in many cases this abuse is a criminal act.

Safety is about the risk management of a situation. There is usually no abuse and no abuser. It is about ensuring the safety and well-being of a vulnerable person in a potentially difficult situation, such as ensuring they have appropriate or adequate care.

Abuse is NOT an accident and nor is an accident necessarily abuse, however neglectful practice that leads to an accident may be.

Being safe is about ensuring that people have the information, skills and support to maintain a safe lifestyle, such as people with learning disabilities being given the skills to use public transport.

3. Safeguarding Principles

The Care Act (2014) reports that the aims of adult safeguarding are:

- To prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- To safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives
- To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible
- To raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.

Six principles continue to underpin all adult safeguarding work:

- Empowerment – presumption of person led decisions and informed consent
- Protection – support and representation for those in greatest need
- Prevention – it is better to take action before harm occurs
- Proportionality – proportionate and least intrusive response appropriate to the risks identified
- Partnership – local solutions. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- Accountability – accountability and transparency in delivering safeguarding

4. Definitions

Clarity of definition is essential in ensuring that safeguarding adult procedures address concerns about the population they are intended to protect and that approaches are consistent.

Who is at risk? Historically the term vulnerable adult was used to describe this cohort. The Care Act (2014) now identifies “adults experiencing or at risk of abuse and neglect”. The act further clarifies that for safeguarding purposes, there must be an impact of an adult’s physical or mental impairment or illness on the person’s well-being, and that as a result of their needs they are unable to protect themselves against the abuse and neglect or the risk of it. The safeguarding duties apply to an adult who has needs for care and support (whether or not the local authority is meeting any of those needs).

Abuse: ‘No Secrets’ defines abuse as: *“a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it”*. The Care Act (2014) extends the range of abusive behaviours to include modern slavery, self-neglect and domestic abuse. The implications of the latter are discussed in section 6 below.

Degree of Harm: Consideration should be given to the severity of ill-treatment, which may include the degree and extent of the harm, the duration and frequency of abuse and neglect, the extent of the premeditation, the susceptibility of the victim to be affected by the ill treatment, and the pressure or degree of threat or coercion. It is the adverse impact of the event on the individual(s) that has to be considered. Sometimes, a single traumatic event may constitute significant harm (e.g. assault). However, significant harm may also occur when there is a compilation of significant events that has an impact on the individual(s).

5. What is reasonable risk for an individual?

Risk is not, in itself, a safeguarding issue, as not all risks will have a negative impact on an individual. Everyone perceives risk differently, it is often viewed as a negative concept and this can prevent people from doing the things that most people take for granted. The governing principle behind good approaches to choice and risk is people have the right to live their lives to the full, as long as that does not stop others from doing the same or place others at risk of immediate harm. One of the five principles of the Mental Capacity Act (2005) states that “a person is not to be treated as unable to make a decision merely because he makes an unwise decision”. This includes putting themselves at risk. Therefore the rights of adults to live independent lives and to take the risks they choose need to be weighed carefully against the likelihood of significant harm arising from the situation in question.

If in doubt, contact the Mental Capacity Act Lead within your organisation.

6. Self-Neglect and Self-Harm¹

Historically, self-neglect and self-harm have not routinely been taken through the adult safeguarding process, and unlike the other categories of abuse, there is no perpetrator involved.

The Care Act (2014) includes discussion of self-neglect and defines this by a wide range of behaviours including neglecting to care for one's personal hygiene, health or surroundings. If someone who is considered to be self-neglecting is also considered to have capacity, they are entitled to refuse care, treatment and other health or social care recommendations. For people where there is evidence of entrenched self-neglect but who have been considered to have capacity, it would be helpful to discuss this person with your organisation's safeguarding lead to consider coordinated escalation to the appropriate multi agency forum and/or an assessment of their decisional and executive capacity².

If the person does not have capacity to weigh up choices and to understand their potential consequences of self-neglect then the law allows interventions to be made to protect them from risk. It is recommended that should you have concerns about self-neglect in a person who does not have capacity that you discuss these concerns with your organisation's safeguarding lead.

Mental Capacity can be assessed as an individual's ability to:-

- understand information given to them to make a particular decision
- retain that information long enough to be able to make the decision
- use or weigh up the information to make the decision
- communicate their decision

7. Pressure Ulcers and Adult Safeguarding

Not all pressure ulcers that develop in an adult with care and support needs are the result of neglect. Therefore it follows that not all pressure ulcers should be referred into the Adult Safeguarding process.

Neglect is the deliberate withholding OR the unintentional failure to provide appropriate and adequate care and support such as; lack of appropriate equipment, lack of risk assessment and subsequent action, nutritional assessments, repositioning charts, poor staff awareness of wound development and care, and poor manual handling processes.

All pressure damage that meets, or potentially meets, the threshold of a Serious Incident must be reported as Serious Incidents to the local Clinical Commissioning Group. A Root Cause Analysis must be carried out to understand whether any acts of omission or commission may have led to the pressure ulcer developing. As part of

¹ Additional Reading - SCIE Report 46 'Self-Neglect and Adult Safeguarding: findings from research'. Suzy Braye and David Orr (2011)

² Decisional capacity relates to the person's ability to understand, retain and weigh up information and then to communicate their decision. Executive capacity requires having a plan of how decisions will be put into effect, adapting the plan in response to changing or unexpected circumstances, and being able to delegate tasks to others where they are physically unable to carry out the plan without assistance. Whilst a person's decisional capacity may be clear cut, their ability to put that decision into effect may be less distinct. The distinction between decisional and executive capacity is not a legal concept, but provides a useful conceptual model when working with cases of self neglect.

the process you must determine if the development of a pressure ulcer should be referred as a safeguarding concern, in doing so the following questions should be considered:

- 1) Has there been rapid onset and /or deterioration of skin integrity?
- 2) Has there been a recent change in medical condition e.g. skin or wound infection, other infection, pyrexia, anaemia, end of life care that could have contributed to a sudden deterioration of skin condition?
- 3) Have reasonable steps been taken to prevent skin damage?
- 4) Is the level of damage to the skin disproportionate to the person's risk status? E.g. low risk of skin damage with extensive injury
- 5) Is there evidence of poor practice or neglect?

8. Service User on Service User

Where one service user may have abused or harmed another service user, consideration must be given to whether the abuse was premeditated or targeted, or whether there is a power imbalance (physical or cognitive) between the service users. Where an alleged abuser lacks capacity this does not negate the impact on the victim and a safeguarding alert/referral will need to be considered. This may occur in parallel with an internal incident report.

If there is no power imbalance then the matter is one about risk and behaviour management and should not be taken through the safeguarding route. However, if the incident has occurred because of the lack of support and supervision by the provider then this may be seen as neglectful, which could be a safeguarding issue.

Referral to the Police MUST also be considered in cases of assault. This MUST be reported using your organisation's internal escalation processes.

9. When might a concern become safeguarding?

When deciding if a concern should be taken through the safeguarding route the following principles and considerations should be considered:

- The nature, degree, and seriousness of the alleged incident
- Whether the care provider has responded appropriately to meet the needs of the adult at risk
- The impact upon the individual
- The risk to others
- The wishes of the service user (where they have capacity)
- The severity and likelihood of re-occurrence
- The accumulation of quality concerns within an organisation
- Failure to follow specialist practice guidance (e.g. pressure sores)
- The complexity of the situation that warrants a multi-agency response
- Where "poor quality /practice" by a care provider/individual is considered to be extensive (e.g. missed calls over a weekend leaving a service user in bed without food or medication).

Where there are concerns raised in relation to an adult, it is advised that the health professional considers the referral in the wider context of the individual's family life. Any risks posed in relation to the victim or perpetrator role as a parent/carer to child

or young person must be assessed. If there are concerns, advice should be sought from the organisations children's safeguarding lead (in their absence this should not delay a children's social care referral following local procedures).

10. Deprivation of Liberty Safeguards

Although Deprivation of Liberty issues would not normally be considered through the Safeguarding Adults route there may be occasions when the consequences or implications of bad practice should be considered. Issues that might prompt consideration of raising a safeguarding concern would be if applications are not being initiated by the organisation, where the conditions of the authorisation are not being complied with, where the least restrictive interventions are not being applied or where someone's human rights are not being respected. A Deprivation of Liberty should not be used as a means of restricting a person's access to family and/or friends.

To note - The Law Commission commenced a consultation process in summer 2014 to review DoLS and consider how the law should protect people who need to be deprived of their liberty in order to receive care and treatment. The Law Commission report was published on the 13th March 2017. DH has acknowledged the report and is currently considering the recommendations.

Adult Safeguarding Health Matrix

The Eastern Regional NHS Adult Safeguarding Best Practice Guidance supporting matrix used in this document is based on similar models used by local authorities including Essex and Cambridgeshire.

The aim of the triangle is to demonstrate a potential escalation of an individual's needs if concerns are not adequately managed at each stage. The triangle refers to adults at risk and each band represents their level of need. The levels outlined below are not an absolute definition and there will be cases that do not fit easily into a specific level.



Appendix One: Safeguarding Adults Best Practice Matrix

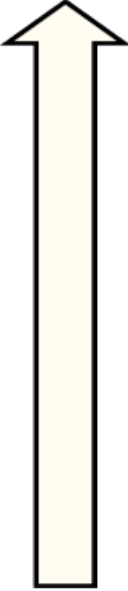
The matrix below contains examples of concerns with an indication of which safeguarding level they may fit into. The examples outlined are not an exhaustive list and do not provide an absolute definition. There will be cases that do not fit easily into a specific level and advice should be sought from your organisation's Adult Safeguarding Lead if there is any query as to which level a concern should be placed in. If in doubt and no expert safeguarding advice is available, complete a Safeguarding Adults referral. **In addition all concerns must be reported in line with your organisation's internal escalation processes.**

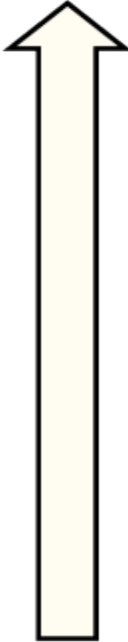
If an adult with care and support needs either died or experienced serious harm as a result of abuse or neglect and there is reasonable cause for concern that agencies could have worked together more effectively to protect the adult, a Safeguarding Adult Review may need to be considered and you should discuss this with your safeguarding lead.

Every person has the right to have their concerns reported through the correct procedures; this may include a safeguarding referral. If a person does not have capacity to make this decision you must consider whether a safeguarding referral needs to be made in their best interests. In line with the Duty of Candour expectations, every healthcare organisation and everyone working for them or on their behalf must be honest open and truthful in all their dealings with patients and the public. Where harm has been, or may have been, caused to a patient by an act or omission of the organisation or its staff, the patient must be informed.

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL SHOULD BE CONSIDERED REFERRAL TO POLICE	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
PHYSICAL (FALLS)	<ul style="list-style-type: none"> Isolated incident (risk assessment reviewed, associated care plan in place. Risk assessment and associated care plan in place but is not being followed. There is no harm to the person. 	<ul style="list-style-type: none"> One person experiencing recurring falls whilst in a care setting or receiving care services (risk assessment reviewed, care plan reviewed, appropriate referral made to relevant health professional) and no harm has occurred One off fall of more than one person within the same care setting and no harm has occurred 	<ul style="list-style-type: none"> Fall where serious harm occurs whilst in receipt of care (e.g. fractured long bone). Consider referral as a serious incident if this meets the framework criteria. 	<ul style="list-style-type: none"> Fall causing serious or significant harm to person, leading to the need for medical intervention where there has been previous concerns identified Previous concerns identified but not addressed by organisation Insufficient prevention measures in place such as training, supervision & auditing Numerous falls affecting more than one person from the same care setting or care provider requiring medical treatment. 	<ul style="list-style-type: none"> One fall causing catastrophic harm to one person possible-hospitalisation / irreparable damage / death where there has been previous concerns identified Insufficient prevention measures for care providers in place such as training, supervision & auditing.
PHYSICAL	<ul style="list-style-type: none"> Staff error causing no/little harm, e.g. superficial skin friction mark Minor events that still meet criteria for 'incident reporting' 	<ul style="list-style-type: none"> Isolated incident involving service user on service user inexplicable very light marking found on one occasion 	<ul style="list-style-type: none"> Inexplicable marking or lesions, burns, cuts or grip marks on a number of occasions Accumulation of minor injuries on one person or within one working area e.g. ward, care home 	<ul style="list-style-type: none"> Inappropriate restraint Inexplicable fractures/injuries to any part of the body that may be at various stages in the healing process 	<ul style="list-style-type: none"> Assault Grievous bodily harm/assault leading to significant harm, irreversible damage or death

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
<p>PHYSICAL (PRESSURE ULCERS)</p>	<ul style="list-style-type: none"> Pressure damage with no evidence of neglect OR failure to provide adequate care or pressure relieving equipment. Person has capacity and makes an informed decision to decline treatment. A pressure ulcer develops. 	<ul style="list-style-type: none"> Pressure damage that meets the threshold of a serious incident should be reported. As part of the SI process, the following questions must be considered: <ol style="list-style-type: none"> Has there been rapid onset and /or deterioration of skin integrity? Has there been a recent change in medical condition e.g. skin or wound infection, other infection, pyrexia, anaemia, end of life care that could have contributed to a sudden deterioration of skin condition? Have reasonable steps been taken to prevent skin damage? Is the level of damage to the skin disproportionate to the person's risk status for skin damage? e.g. low risk of skin damage with extensive injury. Is there evidence of poor practice or neglect? 	<ul style="list-style-type: none"> Person not risk assessed with regards to pressure ulcers risk and management and harm occurs Failure to provide suitable pressure relieving equipment and harm occurs Failure to follow the advice of clinical specialists and harm occurs Pressure ulcers that have been investigated through the SI process and have found to be preventable AND the 5 questions outlined in box 2 have been considered. <p>If this affects more than one person, <u>Organisational Abuse should be considered</u></p>	<p>As box 3.</p> <p>If this affects more than one person, <u>Organisational Abuse should be considered</u></p>	<ul style="list-style-type: none"> Person not risk assessed with regards to pressure ulcers risk and management leading to catastrophic harm/possible hospitalisation/irreparable damage/death Failure to provide suitable pressure relieving equipment / follow the advice of clinical specialists leading to catastrophic harm/possible hospitalisation/irreparable damage/death <p>If this affects more than one person, <u>Organisational Abuse should be considered</u></p>
<p>MEDICATION</p>	<ul style="list-style-type: none"> Adult does not receive prescribed medication (missed/wrong dose) on one occasion and no harm occurs Minimal harm to one person but robust prevention measures in place such as training, supervision & auditing 	<ul style="list-style-type: none"> Recurring missed medication or administration errors in relation to one service user that cause no harm and no ongoing concerns Prevention measures in place such as training, supervision and auditing 	<ul style="list-style-type: none"> One off medication error to more than one person - no harm caused Recurring missed medication or errors that affect more than one adult and/or result in harm Medication error causing serious or significant harm to person, leading to the need for medical intervention Previous concerns identified / ongoing ineffectiveness Insufficient prevention measures in place such as training, supervision & auditing Appearing to be over medicated 	<ul style="list-style-type: none"> Deliberate maladministration of medications Covert administration without proper medical supervision 	<ul style="list-style-type: none"> Recurring errors, or an incident of deliberate maladministration, that results in ill-health or death. Catastrophic harm to more than one person leading to hospitalisation/long term effects/death
<p>SEXUAL</p>	<p>Every person has the right to have their concerns reported through the correct procedures; this may include a safeguarding referral. If a person does not have capacity to make this decision you must consider whether a safeguarding referral needs to be made in their best interests.</p>		<ul style="list-style-type: none"> Isolated incident when an inappropriate sexualised remark is made to an adult and no or little distress is caused Verbal sexualised teasing that causes offence <p>NB: The individual should be offered a referral to the police</p>	<ul style="list-style-type: none"> One off or recurring sexualised touch or isolated/recurring masturbation without consent Attempted penetration by any means (whether or not it occurs within a relationship)without consent Sexual harassment Sexualised relationship between staff and a service user 	<ul style="list-style-type: none"> Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user Sex without consent/rape Being made to look at pornographic material without consent Being subject to indecent exposure

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
FINANCIAL	<p>All allegations of financial abuse should be discussed with the safeguarding team to establish if harm has been caused and a referral is required.</p> 		<ul style="list-style-type: none"> Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest Adult denied access to his/her own funds or possessions Staff/carers personally benefit from the support they offer service users, e.g. accrue 'reward points' on their own store loyalty cards when shopping Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered 	<ul style="list-style-type: none"> Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control Personal finances removed from adult's control 	<ul style="list-style-type: none"> Fraud/exploitation relating to benefits, income, property or will Theft
NEGLECT (CLINICAL CARE PLANS)	<ul style="list-style-type: none"> Person centred, evidence-based clinical care plan in place and being followed. Linked to appropriate risk assessment. NOT regularly reviewed but no harm occurs <p>If this affects more than one person, consideration must be given to organisational abuse.</p>	<ul style="list-style-type: none"> Clinical care plan not person centred, not linked to appropriate risk assessment. No harm. 	<ul style="list-style-type: none"> Poor quality clinical care plans affecting one person, causing harm or distress. Previous concerns about clinical care plans not addressed locally. 	<ul style="list-style-type: none"> Poor quality clinical care plans leading to harm or distress to more than one person – consideration must be given to possible organisational abuse 	<ul style="list-style-type: none"> Poor quality clinical care plans leading to catastrophic harm to one person possible-hospitalisation / irreparable damage / death Poor quality clinical care plans causing significant harm to more than one person Insufficient prevention measures in place such as training, supervision & auditing
NEGLECT (DISCHARGE FROM A CLINICAL SETTING)	<ul style="list-style-type: none"> Deterioration of person due to medical condition – all support services in place <p>CATEGORY INTENTIONALLY LEFT BLANK</p>	<ul style="list-style-type: none"> Poor discharge planning from a clinical setting leading to inconvenience but no harm or distress. Lack of stimulation/opportunities for people to engage in social and leisure activities Person's views not sought, person not involved in care planning process. Denial of individuality and opportunities for people to make informed choices and take responsible risks Care-planning documentation not person-centred 	<ul style="list-style-type: none"> Poor discharge from clinical setting leading to support services not being set up. Causes harm or distress to person. Rigid/inflexible routines Dignity is undermined, e.g. lack of privacy during support with personal care needs Care-planning documentation not person-centred, advice given to organisation but no improvements made Organisation does not have policies or practices that recognise or deal with safeguarding issues. 	<ul style="list-style-type: none"> Poor discharge planning from a clinical setting, failure to refer person to appropriate support services, leading to significant harm. Bad practice unreported and going unchecked Unsafe and unhygienic living environments in a care setting 	<ul style="list-style-type: none"> Poor discharge planning from a clinical setting, failure to refer person to appropriate support services, leading to catastrophic harm/possible hospitalisation/irreparable damage/death Staff misusing their position of power over people Over-medication and/or inappropriate restraint used to manage behaviour within an institutional setting Widespread, consistent ill treatment within an institutional setting
ORGANISATIONAL	<ul style="list-style-type: none"> Isolated incident when inappropriate prejudicial remark is made and no or little distress is caused 	<ul style="list-style-type: none"> Care planning fails to address diversity associated needs for a short period Isolated incident of teasing motivated by prejudicial attitudes 	<ul style="list-style-type: none"> Inequitable access to service provision as a result of diversity issue Recurring taunts Recurring failure to meet specific needs associated with diversity 	<ul style="list-style-type: none"> Being refused access to essential services Denial of civil liberties, e.g. voting, making a complaint Humiliation or threats 	<ul style="list-style-type: none"> Hate crime resulting in injury/emergency medical treatment/fear for life Hate crime resulting in serious injury or attempted murder/honour-based violence
DISCRIMINATORY					

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
PSYCHOLOGICAL	CATEGORY INTENTIONALLY LEFT BLANK	<ul style="list-style-type: none"> Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undermined, but little or no distress is caused 	<ul style="list-style-type: none"> Treatment that undermines dignity and damages esteem Denying or failure to recognise an adult's choice or opinion Frequent verbal outburst Withholding of information to disempower 	<ul style="list-style-type: none"> Humiliation Emotional blackmail (threats of abandonment/harm) Taunts or verbal outbursts that cause distress 	<ul style="list-style-type: none"> Denial of human rights/civil liberties Prolonged intimidation Vicious personalised verbal attacks
DEPRIVATION OF LIBERTY SAFEGUARDS	CATEGORY INTENTIONALLY LEFT BLANK	<ul style="list-style-type: none"> Isolated incident of DoLs application not made in timely manner or conditions not being complied with Isolated incident of a more restrictive method of control being used than is necessary 	<ul style="list-style-type: none"> Lack of policy or practices that recognise deprivation of liberty issues <p>If this affects more than one person, <u>organisational abuse should be considered</u></p>	<ul style="list-style-type: none"> Restriction of liberty repeatedly unreported 	<ul style="list-style-type: none"> Restriction of liberty so significant that evidence of neglect or physical harm has occurred as described in the above categories
SELF-NEGLECT	Person has capacity and is making own choices about self-care	<ul style="list-style-type: none"> Care plans do not appropriately support interventions to manage risk of self-neglect Risks of self-neglect are not explored with the person 	If the person does not have capacity and there is perceived harm or they are refusing interventions to prevent harm, this should be discussed with your organisation's safeguarding lead	If the organisation's approach to self-neglect is of concern, <u>Organisational Abuse should be considered</u>	If the organisation's approach to self-neglect is of concern, <u>Organisational Abuse should be considered</u>
DOMESTIC ABUSE	Refer to DASH risk assessment (http://www.dashriskchecklist.co.uk/index.php?page=dash-2009-model-for-practitioners)			<ul style="list-style-type: none"> Sexual, emotional, financial, or physical abuse from family members Sexual, emotional, financial, or physical abuse from intimate or previously intimate partner 	<ul style="list-style-type: none"> Forced marriage "Honour" violence
MODERN SLAVERY	NB: consideration of the safety of all members of the household or family MUST be made Discuss with safeguarding lead and refer to DASH risk assessment (http://www.dashriskchecklist.co.uk/index.php?page=dash-2009-model-for-practitioners) 	There is also a national Modern Slavery Helpline: 08000 121 700		CATEGORY INTENTIONALLY LEFT BLANK	<ul style="list-style-type: none"> Any concerns about slavery, human trafficking, forced labour and domestic servitude must be reported to the police

Original Contributors

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 Cambridge and Peterborough NHS Foundation Trust
 Cambridge University Hospitals NHS Foundation Trust
 Cambridgeshire and Peterborough Clinical Commissioning Group
 Cambridgeshire Community Services
 Castle Point and Rochford Clinical Commissioning Group
 Colchester Hospital Foundation NHS Trust
 East Coast Community Healthcare CIC
 East of England Ambulance Trust
 Hinchingsbrooke Healthcare NHS Trust
 Ipswich Hospital NHS Trust
 James Paget University Hospitals NHS Foundation Trust
 Mid Essex Clinical Commissioning Group
 Mid Essex Hospital Trust
 NHS England
 Norfolk and Waveney Cluster Clinical Commissioning Groups
 Norfolk Community Services
 North East Essex Clinical Commissioning Group
 North East London NHS Foundation Trust
 North Essex Partnership University NHS Foundation Trust
 Peterborough and Stamford Hospital NHS Trust
 Provide
 South Essex Partnership Trust (SEPT)
 Southend Clinical Commissioning Group
 Southend University Hospital NHS Foundation Trust
 Suffolk Community Healthcare (Serco)
 The Princess Alexandra Hospital NHS Trust
 Thurrock Clinical Commissioning Group
 West Essex Clinical Commissioning Group
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