SAFEGUARDING ADULTS IN CHESHIRE WEST AND CHESTER
BREAK THE SILENCE

Part 2: Safeguarding Adults Procedures for reporting allegations, concerns or suspicions of abuse

Inter-Agency Policy,
Procedures and Guidance

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Are available on request

Part 2 Safeguarding Adults in Cheshire West and Chester - Procedures for reporting allegations, concerns or suspicions of abuse

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1. INTRODUCTION

The protection of vulnerable adults is one of the most important tasks facing social and health care services. Awareness of the issues is growing due to public and media interest. In 2000 when 'No Secrets' was published the task of co-ordinating a response to abuse allegations was charged to local authorities, who in the main have delegated this task to Social Service departments. Sections in brackets refer to sections in 'No Secrets'.

"If abuse is not acknowledged people cannot be protected, or given support to recover, and, in those cases where other adults may be at risk, they too are left exposed to further abuses. Hence a failure to acknowledge abuse may lead to failures in prevention as well as in response."

(Brown, H., 1998, page 387)

Once abuse has been highlighted or is suspected it is the responsibility of the person who is told, sees, suspects or hears about the abuse of a vulnerable adult to take action. This document describes the process for reporting and investigating suspected incidents of abuse. These procedures have been developed in conjunction with the Safeguarding Adults Policy – Part 1.

2. ALERTING – WHAT TO DO AND WHO TO TELL

Anyone reading this document should consider themselves as a potential alerter, it is the responsibility of any member of staff from any agency to take action if they suspect the abuse of a vulnerable adult.

Abuse may be **witnessed**.

You may **be told** about abuse by either the vulnerable person themselves (direct disclosure) or by someone else who has been told about or who has witnessed abuse.

2.1 Responsibility of the person who is first aware of the situation to;

STEP 1: Make sure the person is safe – this may mean calling emergency services if the person is in danger or requires medical treatment.

STEP 2: Inform your line manager or someone more senior if the allegation is against your manager. If there is evidence of a criminal act e.g. a physical assault, theft, neglect or sexual assault the manager should contact the police being careful to record & preserve evidence.

STEP 3: Record any conversations or observations in the person's own words, date and time the record.

STEP 4: Preserve any evidence (if applicable) i.e. do NOT disturb or destroy any articles that could be used as evidence, do Not wash the person unless this is associated with any first aid treatment that may be necessary. (See appendix 4)

2.2 Responsibilities of Line Managers – All Agencies

Once the allegation or suspicion has been raised with the line manager of an agency, s/he must decide without delay the most appropriate course of action.
It is the responsibility of the line manger to:

STEP 1: Deal with immediate needs – ensure that the victim of the alleged abuse is safe.

- Ensure any necessary emergency treatment is arranged.
- Ensure that no forensic evidence is lost.
- If the alleged perpetrator is also a vulnerable adult, ensure a member of staff is allocated to attend to their needs and that other service users are not put at risk.

STEP 2: Clarify

- The facts stated by the member of staff/service user but do not discuss the allegation with the alleged perpetrator.
- Take any necessary personnel action if the alleged perpetrator is a member of staff (refer to own HR policy).
- Check out issues of consent and confidentiality.
- Ensure that the situation falls within the safeguarding adults procedures i.e. meeting the definition of a vulnerable adult. Refer to the Thresholds of instigating adult safeguarding appendix 1. To be completed even if no incidents occurred.
- Record any action taken.
- If you are the manager in regulated service complete the necessary regulation requirements and inform CQC e.g. form 19 for abuse.

STEP 3: Making a referral:

- If the incident falls within the 'thresholds for adult safeguarding' (see appendix 1) the manager must make a referral via Cheshire West and Chester Advice and Contact Team (ACT) – by ringing the following number **0300 123 8 123 (option2)**

(Office hours 8.30am-5pm Monday to Thursday, Friday 8.30am - 4.30pm)

Out of Hours Service (Social Care) (operates when day offices are closed) 01244 977277

You should contact Cheshire West and Chester (CWAC) even **if the person is resident in CWAC but is paid for by another authority**. If

this is the case you should also contact the 'funding' authority. Referrals from July 2011 should be made by telephoning the Advice and contact team (number above) or out of hours team and make a referral that way, for further details please see rules of ordinary residence section 3.

Information that social services/police will need from you:

- Personal details of vulnerable adult (name, address, date of birth, ethnicity, current whereabouts, language spoken).
- Who you are and why you are involved.
- What happened, when and where?
- Details of alleged abuser(s) (name, address, date of birth) and relationship to vulnerable adult(s).
- Are there any other people at risk including any children?
- Details of any other agencies involved.
- Is the vulnerable person aware of the referral?
- Remember – do not start investigating the incident(s) yourself.

You should also:

- Contact the police if you think a crime has been committed (if the allegation involves a member of staff you should contact a senior manager in your organisation first).
- Contact the Care Quality Commission (CQC) if the person is in a regulated service.

Timescales

When a referral is received by CWAC – advice and contact team or the emergency duty team will make a decision within **24 hours whether it meets the criteria** – if not referrer should be notified of this decision. If accepted as safeguarding the referral should be passed on to the appropriate social work team/safeguarding unit within 24 hours of referral being received.

Strategy discussion/meeting – this is a planning meeting and should happen within **5 working days**, any actions being recorded.

Professional meeting to discuss investigation findings will happen within **20 working days** of the strategy discussion/meeting.

Case conference/review of safeguarding – within **3 months** of the date when the referral was received, unless there are good reasons why not, these should be documented.

3. DECISION

A range of factors will be taken into account when deciding whether a case warrants further action to be taken under the Inter-Agency policy and procedures, and include:

- Historical abuse – a decision will be taken as to whether this can be investigated under safeguarding, a general rule should be that cases are investigated as soon after the incident happens as possible; as vital evidence/witnesses may be lost if a period of time elapses.
- Childhood abuse will not be investigated under the adult safeguarding procedures. Refer to LCSB policy and procedures.
- The level of vulnerability and the risk to others in the same or similar situation.
- The views and informed opinions of staff in the partner agencies.
- The nature and extent of alleged abuse.
- The length of time over which the abuse is alleged to have happened.
- Whether the abuse was a single case or took place over a longer period of time.
- The impact of the abuse on the individual.
- The intent of the alleged perpetrator.
- The capacity of the alleged perpetrator.
- The risk of repeated incidents or the risk of escalation of seriousness of incident

4. WHAT TO DO IF THE PERSON DOES NOT LIVE IN CWAC OR WHERE ANOTHER LOCAL AUTHORITY PAYS FOR THEIR CARE

In the circumstances where a person lives outside of CWAC but where the local authority retains responsibility for their placement:

(a) The procedures, which operate within the authority where the abuse occurred, will apply.

(b) The Social Services Contracts and (CQC) both in CWAC AND the host authority, must be notified of any incidents of abuse/assault.

(c) The relevant CWAC Social Work Team must allocate a Social Worker to support the abused person.

If however the person lives in CWAC but is funded by another authority CWAC as the host authority will:

(a) Co-ordinate and chair any strategy/other meetings, a decision about who is best placed to investigate such cases will be taken at the initial strategy meeting. CWAC reserves the right to ask the funding authority to investigate.

5. WHAT TO DO IF THE PERSON DOES NOT FIT THE DEFINITION OF A VULNERABLE ADULT

It has to be recognised that not all adults will fit within the definition, however some of these adults may be at risk from abuse because of other factors such as lifestyle choices/other reasons such as homelessness, drug/alcohol abuse etc. In such cases advice can be sought from the advice and contact team about voluntary services/options services available to people. Any agency can take the lead in such cases. Options should be given to adults who may be putting themselves at risk through self neglect or lifestyle choices. The risk assessment can be used in such cases.

6. PREVENTION OF ABUSE / STANDARDS FOR A SAFER SERVICE

6.1 We have agreed to work towards a set of standards that will create a safer service. All agencies/organisations will need to develop their own guidelines, which will address the following standards:

(a) Rigorous Recruitment and Selection (7.2), which will facilitate effective intervention to recruit the best staff, and prevent the recruitment of abusers. CRB/ISA checks will also form part of this.

(b) Services that are person centred, reflective, pro-active and open to question, observation and change.

(c) Safeguarding vulnerable adults becomes embedded in the culture of all organisations.

(d) Investigations of allegations of abuse are immediate, consistent and open.

(e) Disciplinary Procedures are compatible with the responsibility to protect vulnerable adults. (6.27)

(f) Procedures exist for reporting to the police when allegations of criminal behaviour are made against staff.

(g) Internal guidelines which relate to the Inter-agency procedure for adult protection/safeguarding.

(h) Commissioners and purchasers of services will ensure that adherence to the standards of a safer service are part of the contract. (5.1 and 5.4)

(i) A “whistle blowing policy” to support and protect staff making complaints, allegations or expressing concerns about abuse. (5.5)

(j) Operational guidelines to maintain the best evidence based practice which deal with:

(i) Challenging behaviour

(ii) Personal and intimate care

(iii) Physical intervention

(iv) Sexuality

(v) Medication

(vi) Handling of users money

(vii) Risk Assessment and Management (7.5)

(k) A Code of conduct that sets unambiguous boundaries for staff/service user relationships and states that a sexual relationship that develops between a service user and a member of staff will always be regarded as abuse. (6.35)

(l) All organisations develop internal policies for dealing with staff who behave in a way in their personal life that may have an affect on their ability to work with adults who are vulnerable. (Appendix 6)

(m) Ensuring that users, carers and the public are aware of the Policy, Procedure and Guidance through a variety of different communication mechanisms. (4.1, 5.1, 7.1, 7.7 and 7.8)

(n) All staff receive ongoing personal training and development and are regularly supervised. (3.18, 5.1, 5.2 and 5.3)

(o) All staff receive specific training in relation to adult abuse and safeguarding.

APPENDIX 1

Thresholds for initiating Safeguarding Procedures

Protecting vulnerable people from abuse, harm and exploitation in Cheshire West and Chester is one of the councils' and its partner's key priorities, with an increasing number of referrals and budgetary constraints it is important to ensure that resources are targeted to make the most effective use of them. However, establishing whether abuse has taken place is not always straightforward. This section in the procedures aims to support/guide frontline managers and staff to distinguish between **poor practice** and **abuse**. Where poor practice is felt to have occurred it may be more practicable for the provider to take appropriate action. Where abuse is identified the safeguarding procedures should be implemented.

On receiving a safeguarding alert it is important to determine whether it is appropriate for the concern to be dealt with under safeguarding procedures**.** Before safeguarding procedures are initiated, some questions must first be considered:

- does the possible abuse relate to a vulnerable adult? (refer to inter-agency policy for definition of vulnerable adult)
- does the adult have capacity to consent to what has occurred, but if so did they do so under duress?
- is there a duty of care that has been breached?
- has the adult experienced significant harm? *Significant harm is defined as "…ill-treatment (including sexual abuse and forms of ill treatment that are not physical); the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, emotional, social or behavioural development"*. [Law Commission 1995]
  (See appendix 5 – flowchart)

What degree of abuse justifies intervention through Safeguarding Procedures?

In determining what degree of harm justifies intervention through Safeguarding Procedures, the factors to consider will include:

- the vulnerability of the victim
- balance of power between victim and alleged perpetrator
- capacity of victim and perpetrator
- the nature and extent of the harm caused
- the frequency of incidents
- the impact on the person
- the views of the person and their carers
- whether the harm caused constitutes a criminal offence
- whether others (vulnerable adults or children) are at risk

It is important to note that abuse may not be deliberate or intentional; however, where **significant harm** has occurred as a result of an act or omission, whether intentional or not, then Safeguarding Procedures should be initiated.

Determining whether or not abuse of a person 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 significant harm. The multi agency arrangements for responding to concerns exist to establish whether or not abuse has occurred. It is very important that these arrangements (Strategy discussion and Strategy meeting) are triggered if there is a possibility that abuse has occurred. Some very serious abuse only comes to light because people raising the alert have drawn the attention of social care or police to what may appear to be relatively minor concerns. In some cases it is the *repetition* of minor actions or omissions that collectively will amount to abuse. The expectation in the Cheshire West and Chester multi agency Safeguarding Adults Procedures of anyone suspecting abuse is **if in doubt report.**

However, 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 or even catastrophic consequences for some individuals. However, in many instances the Provider Manager will be the appropriate person to take appropriate action.

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 abuse which should trigger Safeguarding Procedures. The following table illustrates ***examples*** of circumstances in which investigations should be led by providers and those which should be led by Adult social care teams; please note this is ***not*** an exhaustive list.

Area of concern	***Provider-led investigation*** **Poor practice which requires actions by a provider organisation e.g. homes, ward or domiciliary care manager**	***Adult Social Care led investigation*** **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 on one or two occasions and no significant harm occurs 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 referred under safeguarding adult's procedures. **Action: provider manager to take appropriate action and complete 'report on low level incidents' – send to Adult safeguarding team.**	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 investigation Harm: malnutrition, dehydration, constipation, tissue viability problems **Action: manager to make safeguarding referral**
2.Failure to provide assistance to maintain continence	Person does not receive necessary help to get to toilet to maintain continence or have appropriate assistance such as	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

Area of concern	*Provider-led investigation* **Poor practice which requires actions by a provider organisation e.g. homes, ward or domiciliary care manager**	*Adult Social Care led investigation* **Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures**
	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 referred under safeguarding adult's procedures. **Action: provider manager to document and deal with appropriately – as above.**	one person – neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation Harm: pain, constipation, loss of dignity, humiliation, skin problems **Action: manager to make safeguarding referral**
3. Failure to seek assessment re pressure area management	Person known to be susceptible to pressure ulcers has not been formally assessed with respect to pressure area management but no discernible harm has arisen. This may need to be dealt with under disciplinary procedures. **Action: same as 1.**	Person is frail and has been admitted without formal assessment with respect to 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 procedures should be instigated. Harm: avoidable tissue viability problems. **Action: manager to make safeguarding referral**
4. Medication not administered	Person does not receive medication as prescribed on one or two occasions but no significant harm occurs. Internal investigation should be undertaken, possible disciplinary action depending on severity of situation including type of medication. **Action: same as 1.**	Person does not receive medication as a recurring event, or it is happening to more than one person. Neglectful practice, regulatory breach, breach of professional code of conduct if nursing care provided. Dependant on degree of harm, possible criminal offence. Safeguarding procedures should be implemented. Harm: pain not controlled, risk to health, avoidable symptoms **Action: manager to make safeguarding referral**
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. **Action: same as 1.**	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 – safeguarding procedures should be instigated Harm: Injuries such as falls and fractures, skin damage, lack of dignity, loss of confidence for the person **Action: manager to make safeguarding referral**

Area of concern	*Provider-led investigation* **Poor practice which requires actions by a provider organisation e.g. homes, ward or domiciliary care manager**	*Adult Social Care led investigation* **Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures**
6. Failure to provide support to maintain mobility	Person not given recommended assistance to maintain mobility on one or two occasions. **Action: same as 1.**	Recurring event, or is happening to more than one vulnerable adult resulting in reduced mobility. Harm: loss of mobility, confidence and independence or continence issues. **Action: manager to make safeguarding referral**
7. Failure to provide medical care	Vulnerable adult 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 in a timely manner. **Action: same as 1.**	Vulnerable adult is provided with an evidently inferior medical service or no service, and this is likely to be because of their disability, age, or illness. Harm: pain, distress, deterioration in health **Action: manager to make safeguarding referral**
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. **Action: same as 1.**	Person is frequently spoken to in a rude, insulting, humiliating or other inappropriate way or it happens to more than one person. Regime in a care home doesn't respect people's dignity and staff frequently use derogatory terms and are abusive to residents. Regulatory breach - refer under safeguarding procedures. Harm: demoralisation, psychological distress, loss of self-esteem **Action: manager to make safeguarding referral**
9.Significant need not addressed in Care Plan	Person does not have within their **Care Plan**/Service Delivery Plan/Treatment Plan a section which addresses 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. **Action: same as 1.**	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.* **Action: manager to make safeguarding referral**
10.Care/support Plan not followed	Person's needs are specified in Treatment or **Care/Support Plan**. Plan not followed, need not met as specified but no harm occurs. **Action: same as 1.**	Failure to address a need specified in vulnerable adult's Plan results in harm. This is especially serious if it is a recurring event or is happening to more than one vulnerable adult **Action: manager to make safeguarding referral**
11. Failure to respond to person's mental health needs	Vulnerable adult known to mental health services is identified as being at risk. Previous risk assessment identifies same day response is required. Response is not	Patient is known to be high risk, a timely response is not made and harm occurs. Harm: physical injury, emotional distress, death **Action: manager to make safeguarding**

Area of concern	*Provider-led investigation* **Poor practice which requires actions by a provider organisation e.g. homes, ward or domiciliary care manager**	*Adult Social Care led investigation* **Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures**
	made that day but no harm occurs. **Action: same as 1.**	**referral/may need to refer to CWAC serious case review policy.**
12. Person deprived of liberty without referral for Deprivation of Liberty Safeguards	Person has been formally assessed under the Mental Capacity Act and lacks **capacity** to recognise danger e.g. from traffic. Steps taken to protect them are not 'least restrictive'. Steps need to be reviewed and referral for Deprivation of Liberty Safeguards may be required. **Action: same as 1.**	Restraint/possible deprivation of liberty is occurring or has occurred (e.g. cot sides, locked doors, medication) and vulnerable adult has not been referred for a Deprivation of Liberty Safeguards assessment although this had been recommended. Best interest has been ignored or presumed. Unlawful DoL has occurred). Harm: Loss of liberty and freedom of movement, emotional distress **Action: manager to make safeguarding referral/contact mental capacity co-ordinator**
13. Inappropriate discharge from hospital	Vulnerable patient is **discharged** from hospital without adequate discharge planning involving assessment for care/therapeutic services, procedures not followed but no harm occurs. **Action; same as 1.**	Vulnerable patient is discharged without adequate discharge planning, procedures not followed and experiences harm as a consequence. Harm: care not provided resulting in risks and/or deterioration in health and confidence; avoidable re-admission **Action: manager to make safeguarding referral**
14. 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 investigation, to the satisfaction of person involved. **Action: same as 1.**	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 potentially serious risk to the person. **Action: manager to make safeguarding referral**
15. Abuse of a service user by another service user	One vulnerable adult **verbally abuses or 'taps' or slaps** another vulnerable adult but has left no mark or bruise, victim is not intimidated and significant harm has not occurred. **Action: same as 1.**	Predictable and preventable (by staff) incident between two vulnerable adults where an injury requiring medical attention is required. Harm: physical injury, psychological distress **Action: manager to make safeguarding referral**
16. A vulnerable adult with unstable mental health makes allegations against staff or fellow residents/patients that appear unrealistic/false.	Person is unwell and makes allegations that appear false e.g. staff are trying to poison me with medication. Or person X has assaulted me - they were not on duty at that time. That there is clear and documented evidence supported by assessment that the allegations are due to the person's mental health symptoms and no harm has occurred.	There is no clear evidence docum3ented or otherwise of a mental health presentation that supports the view that the allegation is false. Or the person makes an historical allegation when they are well. **Action: provider manager/hospital staff make a safeguarding referral.**

Area of concern	*Provider-led investigation* **Poor practice which requires actions by a provider organisation e.g. homes, ward or domiciliary care manager**	*Adult Social Care led investigation* **Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures**
	That a doctor and another qualified member of staff responsible for the person's care are able to confirm this. Any plans to support this are clear and reviewed regularly. **Action: same as 1**	

Case example: If a domiciliary care agency misses a visit to a person, on an isolated occasion, and may not be completing all the tasks that are written on the support plan, this is not necessarily a safeguarding issue, unless the consequences of the missed visit put the person at risk of significant harm e.g. if they are dependant on receiving life sustaining medication.

Missed visits that don't have serious impact to health and well being still need to be addressed. It is the responsibility of the provider manager to take the necessary action, this action should be to the satisfaction of the service user/and their families/carers.

What should I do if I am unsure?

If after considering the threshold document you are still unsure as to whether you need to instigate the safeguarding process then you can discuss it with your manager or contact the Advice and contact team (0300 123 8 123) for clarification. Always remember that if **in doubt initiate Safeguarding Procedures**.

If it is not Safeguarding is there anything else I should do?

The importance of recording and monitoring concerns you become aware of needs to be highlighted here. If you have concerns which do not come under safeguarding procedures you can contact:

- Contract Team if the concern is with a domiciliary care agency or care home
- Complaints department
- Commissioning Team if the concern relates to the conduct of a commissioned service

It is also important to record your concerns within your own notes and to discuss these concerns in supervision with your line manager. This is essential as some very serious issues have been brought to light because we have been notified of the repetition of minor actions or omissions that collectively amounted to significant abuse. If you do not instigate a safeguarding referral please complete the template attached and send to the Adult Safeguarding Team, Floor 4, Civic Way, Ellesmere Port. CH65 OBE.

Version 2 – January 2013.

Acknowledgement

Thresholds for instigating adult safeguarding referrals – Knowsley Council 2010.

Thresholds for initiating Adult Safeguarding Referrals or Care Concerns – Cheshire East September 2012

References:

"Safeguarding Adults: a National Framework of standards for good practice and outcomes in Adult Protection" ADSS 2005.

"Thresholds in Adult Protection" Mick Collins, Policy & Development, Powys County Council in *The Journal of Adult Protection* Vol 12 February 2010.

Thresholds for initiating Adult Safeguarding Referrals or Care Concerns – Cheshire East September 2012.

REPORT ON 'LOW LEVEL' SAFEGUARDING CONCERNS.

MONTH .....

SERVICE/NAME OF ESTABLISHMENT…..……

MANAGERS NAME (& contact number)…..……

DATE OF INCIDENT	NAMES OF SERVICE USER/RESIDENT(S) INVOLVED	BRIEF OUTLINE OF INCIDENT	ACTION TAKEN

Form to be completed at the end of each month and sent to Sandra Edwards, Adult Safeguarding Team, Floor 4, Civic Way, Ellesmere Port. CH65 OBE. Sandra.edwards@cheshirewestandchester.gov.uk

APPENDIX 2

GOOD PRACTICE GUIDELINES - DISCLOSURES

If someone discloses abuse to you

DO:

(a) Stay calm and try not show shock

(b) **Listen** carefully rather than question directly

(c) Be sympathetic

(d) Be aware of the possibility that medical evidence might be needed

(e) Tell the person that:

- They did right to tell you
- You are treating this information seriously
- It was not their fault
- You must inform the appropriate manager
- With their consent the manager will contact Social Services.
- The manager will contact social services without their consent in certain circumstances but that their wishes will be made clear throughout
- If a referral is made and they are reluctant to have the incidents investigated, this fact will be recorded and brought to the attention of the relevant Social Work Team Manager
- (If appropriate) the service/agency will take steps to protect and support them

(f) Report to your manager

(g) Write down, as soon as possible and as far as you are able, what the person disclosing said (see later for guidelines on how to record what was said.

(h) Where appropriate record, on a body map, the location of any bruises, cuts and/or abrasions (appendix 2)

(i) Ensure that the information is noted in the case file

DO NOT:

(a) Press the person for more details, although you will need enough information for an initial report and assessment

(b) Stop someone who is freely recalling significant events, as they may not tell you again.

(c) Promise to keep **secrets**; explain that the information will be kept confidential, i.e. information will only be passed to those people who have a “need to know”.

(d) Make promises that you cannot keep (such as “this will not happen to you again”)

(e) Contact the alleged abuser.

(f) Be judgemental (e.g. “why didn’t you run away?”)

(g) Pass on information to anyone who doesn't have a "need to know" i.e. do not gossip

Usually you will have to write up your notes **after** you have responded to a disclosure. A disclosure may only provide part of the picture. However confused the details may seem, they may provide a key to the full story.

You may be criticised and or disciplined for not following the procedures unless you have a good reason. If the procedures are not followed this must be recorded, together with the reasons and the manager or senior manager must validate it.
If you choose not to report allegations or concerns through these channels without good reason you may be regarded as colluding with the abuse.

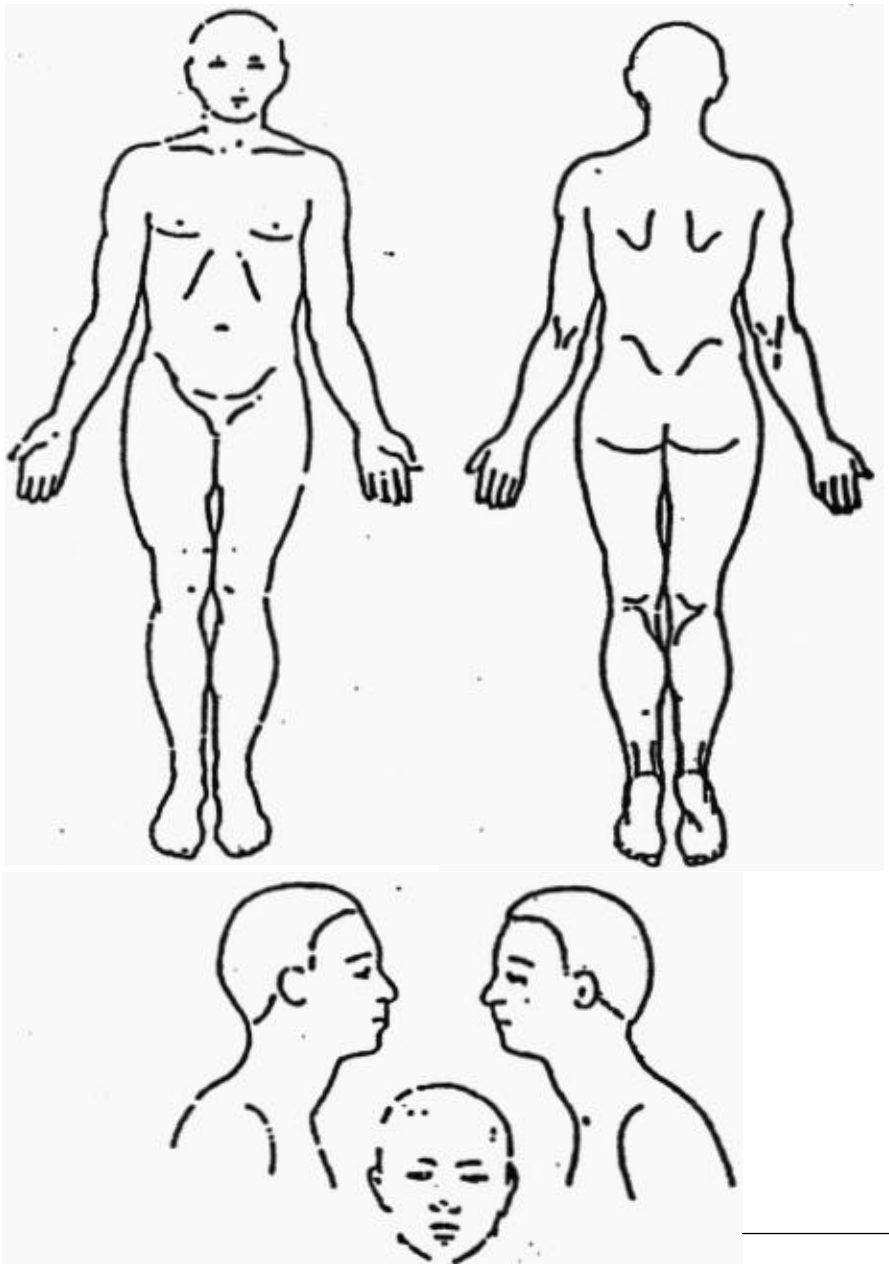
References

Skinner, B et al (1998), AIMS for Adult Protection – The Alerter Guide, Pavilion Publishing, Brighton.

Blackpool Social Services- Safeguarding Adults Procedures

APPENDIX 3

BODY CHART – TO BE COMPLETED IF THERE ANY PHYSICAL SIGNS/MARKS



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APPENDIX 4

PRESERVING EVIDENCE

Protecting or Preserving Evidence

Your first concern is the safety and welfare of the abused person. However, your efforts to preserve evidence may be vital.

When Police involvement is required they are likely to be on the scene quickly. Preservation of evidence is crucial if the Police investigation is to be effective. What you **DO OR NOT DO** in the time whilst you are waiting for the Police to arrive may make all the difference.

The following checklist aims to help you to ensure that vital evidence is not destroyed.

(A) In situations of physical and/or sexual assault:

(a) If the abused person has a physical injury and it is appropriate for you to examine, always obtain their consent first.

(b) Do not touch what you do not have to. Wherever possible leave things as they are. Do not clean up, do not wash anything or in any way remove fibres, blood, etc. If you do have to handle anything at the scene keep this to a minimum.

(c) Do not touch any weapons unless they are handed directly to you. If this happens, as before, keep handling to a minimum. Place the items/weapons in a clean, dry paper bag.

(d) Preserve the abused person's clothing and footwear, do not wash or wipe them. Handle them as little as possible.

(e) Preserve anything that was used to comfort the abused person, for example, a blanket.

(f) Secure the room, do not allow anyone to enter unless strictly necessary to support you or the abused person and/or the alleged perpetrator, until the Police arrive.

Following allegations of physical and/or sexual assault, consideration will be given to organising a medical examination of the abused person and the alleged perpetrator.

The decision to carry out an examination will be taken during strategy discussion/meeting. Any examination will be carried out by a Forensic Medical Examiner who will be contacted by the Police.

If a medical examination is required:

(a) Ensure that no one has physical contact with **both** the abused person and the alleged perpetrator as cross-contamination can destroy may have to comfort both the abused person and the alleged perpetrator, e.g. if the alleged perpetrator is a service user. You need to be aware that cross-contamination can easily occur (see appendix 1)

(b) Where appropriate, protect bedding and do not wash it.

(c) Preserve any bloodied items.

(d) Preserve any used condoms.

(B) In situations of theft/financial abuse:

(a) Ensure that receipts, bank books, bank statements, benefit books are secured.

(C) Methods of preservation:

(a) For most things use clean brown paper, if available, or a clean brown paper bag or a clean envelope. If you use an envelope do not lick it to seal.

(b) For liquids use clean glassware.

(c) Do not handle items unless necessary to move and make safe.

It is acknowledged that completion of all of the above tasks may not be possible in a traumatic situation.

You are urged to do the best that you can.

(D) Recording the Incident

You should make a written account of what has happened as soon as possible, including:

(a) What you saw/heard/were told

(b) How the incident occurred – do not speculate

(c) The time

(d) The place

(e) The names of the people involved, including other potential witnesses

(f) Any obvious evidence, e.g. weapon, blood

(g) The state of the clothing of the abused person and perpetrator

(h) Any injuries that either the abused person or the alleged perpetrator have received

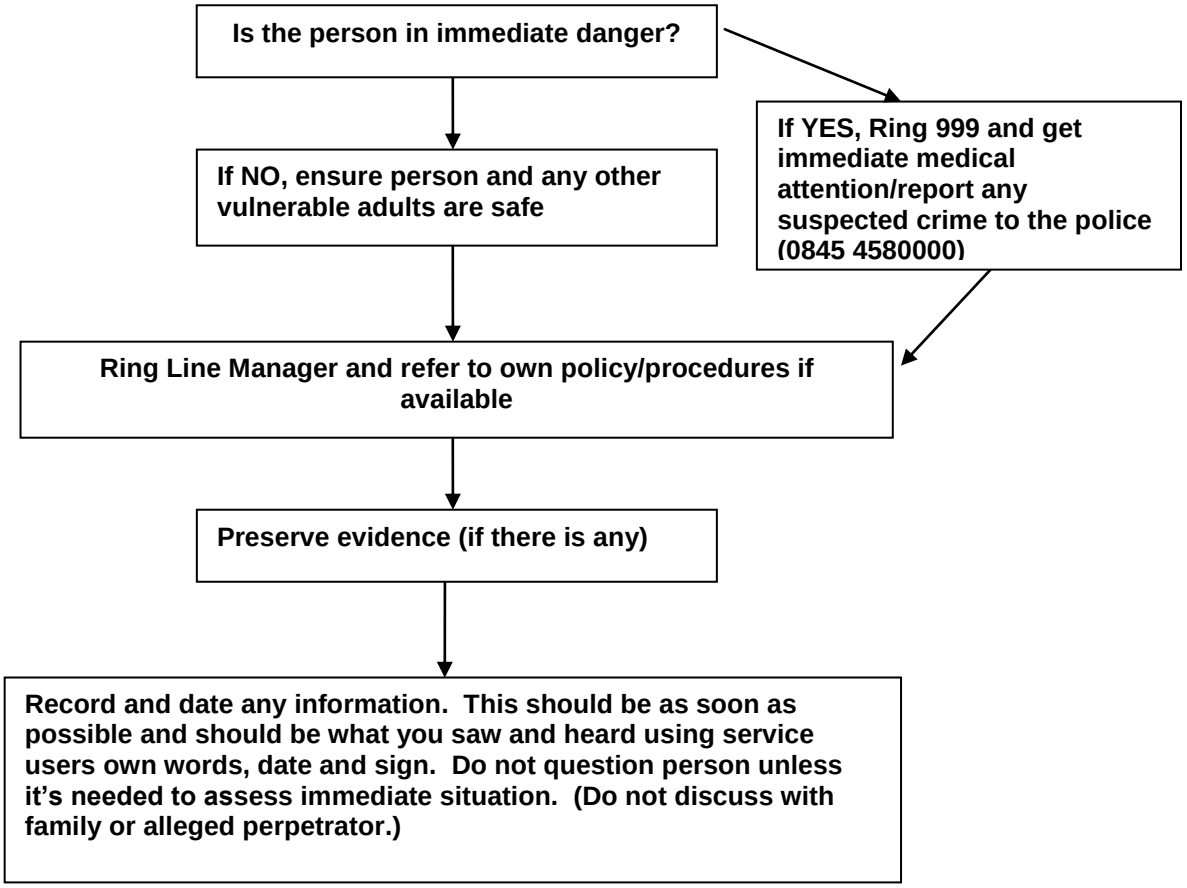
(i) The behaviour and attitudes of the people involved in the incident

APPENDIX 5

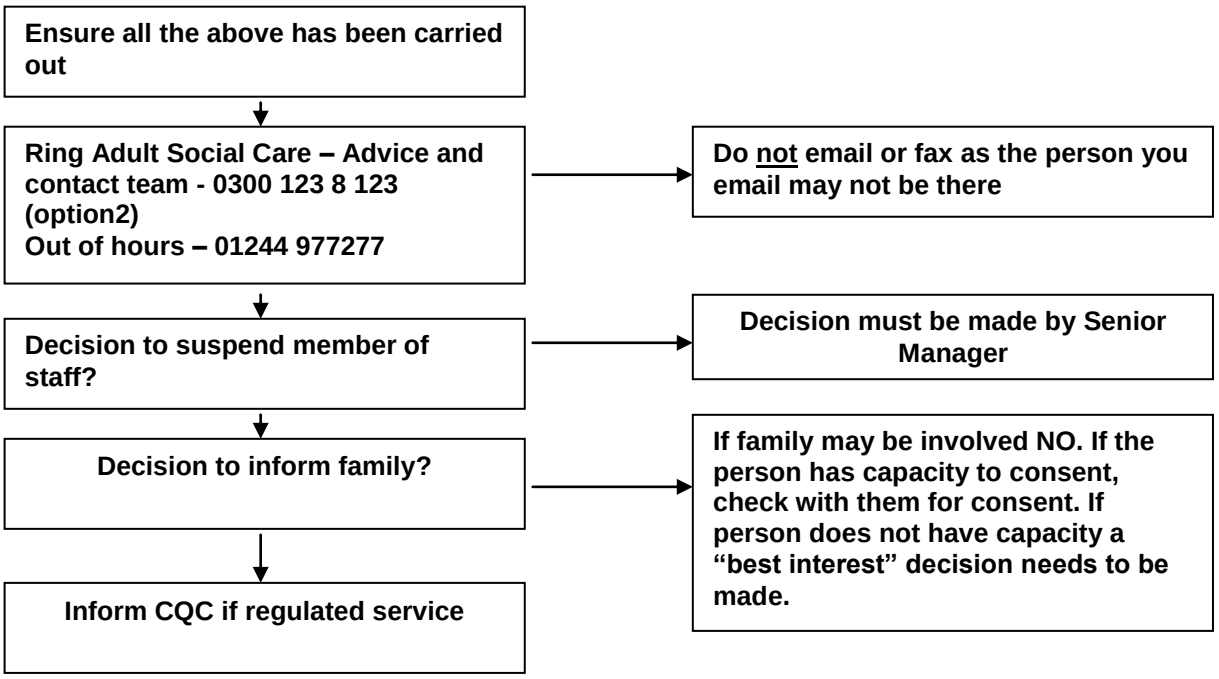
ADULT ABUSE – FLOWCHART

Concern, Allegation, Disclosure or Suspicion of Abuse

Alerter/first person dealing with situation



Manager Responsibilities



APPENDIX 6

Bringing the department or agency into disrepute – Cheshire West and Chester Council

This process and procedure will be activated when an allegation of abuse involves a paid worker, where the allegation is made against them outside their work environment. For example a relative or member of the public makes an allegation against a paid worker.

A safeguarding referral will be completed as normal. However, prior to taking the action further, a discussion must take place between the worker's line manager and a senior manager within CWAC This will confirm appropriate action to take as follows;

1. Assess risk to service user
2. Assess risk to worker
3. Management decision made to contact the police.
4. Worker will be seen by their line manager on their next working day

Options

Decision to complete internal investigation using CWaC disciplinary procedures

During this time, line management will take advice from Human Resources and confirm whether;

1. The worker to continue working in current job, but not alone.
2. Worker to move temporarily to another job whilst investigations are completed.
3. Worker is suspended, whilst investigation is completed. The decision to suspend is taken by the relevant Head of Service

Refer to HR procedures from this point onwards.

Allegations made about a paid member of staff or volunteer outside of CWAC.

If CWAC are made aware of an allegation about a member of staff/volunteer outside of CWAC the senior manager for safeguarding will discuss with ASB members as to whom is most appropriate to share this information with the person's employer. This information will be shared if it is felt that their actions have or could put vulnerable people at risk.

APPENDIX 7 - Referral to Nursing and Midwifery Council (NMC)

Safeguard the health and wellbeing of people using or needing the services of nurses and midwives

Procedures if you are considering making a referral to the NMC

The NMC are the only body with the powers to stop nurses and midwives practising if they present a risk to patient safety.

For more information, you can access the code on their website **www.nmc-uk.org/code**

Being fit to practise means that a nurse or midwife has the skills, knowledge, good health and good character to do their job safely and effectively

The Fitness to Practise directorate of the NMC investigates all allegations made against nurses and midwives questioning their fitness to practise, including allegations of:

- misconduct, for example physical abuse
- lack of competence, for example persistent failure to deliver appropriate care
- bad character, for example a serious legal conviction
- poor health, for example a neglected and untreated dependence on drug or alcohol

Misconduct is behaviour which falls short of that which can be reasonably expected of a nurse or midwife.

The most common examples of misconduct include:

- physical or verbal abuse of colleagues or members of the public
- theft
- significant failure to deliver adequate care
- significant failure to keep proper records

Lack of competence is a lack of knowledge, skill or judgment of such a nature that the nurse or midwife is unfit to practise safely and effectively in any field in which they claim to be qualified, or seek to practise.

Examples of lack of competence:

- over a prolonged period of time a nurse or midwife makes continuing errors
- demonstrates poor practice which involves lack of skill or knowledge poor judgment
- inability to work as part of a team
- difficulty in communicating with colleagues or people in their care
- You identify a training need and set up a supervised support programme for the nurse or midwife, but their work may only show a temporary improvement which slips back when the programme is completed
- The nurse or midwife shows no insight into their lack of competence

- The nurse or midwife demonstrates a persistent lack of ability in correctly or appropriately calculating, administering and recording the administration or disposal of medicines
- The nurse or midwife demonstrates a persistent lack of ability in identifying care needs and subsequently planning or delivering appropriate care

The NMC ask employers, colleagues and members of the public to let them know if they have any reason to be concerned about a nurse or midwife's fitness to practise. They have memorandums of understanding with a range of organisations for sharing information, and will initiate their own investigations in the most serious cases.

The NMC recognise that many of these incidents can be managed at a local level through employment and disciplinary procedures and do not give rise to wider concerns about fitness to practise or patient safety. However, if you have any doubts about this, you must consider referral.

Responsibilities of employers
As an employer you have the power to suspend or dismiss a member of staff, but this may not prevent them from working elsewhere.

The NMC has the legal powers to prevent nurses and midwives from practising if they present a risk to patient safety.
In very serious cases it will therefore be appropriate to refer a nurse or midwife to the NMC at an early stage, even before you conduct your own internal investigation. This allows for the possibility of issuing an interim suspension or restricting the practice of the nurse or midwife concerned until the case has been thoroughly investigated.

If you believe the public's health and wellbeing is at immediate and serious risk, you should contact the NMC straight away.

Responsibilities of none employers

In most cases, it is best to raise your concerns locally first. The employer can sometimes solve issues quickly and fairly without the need for involvement from the NMC. If the employer decides to refer the case to the NMC, they will be able to send all the information from their investigation, which makes the process much quicker. However, if it is not appropriate to rely on the employer for any reason, and if the nurse or midwife potentially poses a threat to patient safety you should report the matter directly to the NMC.

If you believe the public's health and wellbeing is at immediate and serious risk, you should contact the NMC straight away.

You can always contact the NMC for confidential advice on 020 7333 9333 if you are unsure whether to make a referral

APPENDIX 8 - FLOWCHART FOR ASSESSMENT OF MENTAL CAPACITY