WHAT IF…

INCIDENTS BETWEEN PEOPLE IN PROVIDER SETTINGS

The What if …series seeks to provide guidance to aid the identification of an adult safeguarding concern and the action to take.

Immediate Considerations & Actions for providers

- Immediate safety, support, reassurance and care of individuals
- Providers to undertake internal information gathering and response considering; the incident and information gathered from individuals and witnesses, assess if safeguarding referral is appropriate or if it is poor practice that requires in-house response

Action must be taken to safeguard the individual in either case.

If a 'one off' with no injury or distress has been caused, with risk assessments/protection plans and support plans amended, safeguarding may not be required.

If there is no power imbalance, then it may relate to risk and behaviour management, not safeguarding, though it is the responsibility of the provider to ensure a risk assessment is in place for the immediate safety of all Adults at risk .

Consideration for a S42:

Was there a considerable level of harm that was preventable?

Was there a power imbalance between two or more adults that is being used to one's advantage?

Repeat low impact incidents (where no harm)

Agencies must ensure support when person causing harm is also an adult at risk. Reassessment must be completed and care and support plan should ensure safeguards in place.

If incident has occurred due to lack of support and supervision by provider, the safeguarding concern is about the provider.

Additional Issues:

- Wilful neglect
- Relevant capacity and risk assessments absent
- Involvement of family members/carers
- Lack of prompt medical attention
- Criminal offences
- Organisational abuse
- Domestic abuse/coercion and control
- Lack of communication between staff
- Lack of transparency
- Lack of partnership working for advice and support
- Poor safeguarding culture

Has relevant documentation been evidenced?

- Accident/incident form, capacity/ consent, inform relatives/advocates
- Was appropriate medical attention sought?
- Person-centred support plan review and update
- Has a risk assessment for individuals and other residents been implemented?
- What are the views of the adult or their family?
- Does the situation involve staffing levels or staff members?
- Is the incident part of a pattern?
- Are staff skilled to support those involved?
- Has the root cause been identified?
- Is communication between staff robust?
- Training record and competency checks
- Up-to-date policies and procedures
- Action planning and monitoring for continuous improvement
- Is Reg. 20 duty of Candour relevant?
- Should the incident be reported to CQC?

Issues Identified by Safeguarding Adult Reviews

- Consequences of traumatic events in person's life
- Sexual abuse by others not being identified
- Unmet needs in dementia care
- Domestic abuse
- Lack of specialist knowledge and skills from staff
- Staff unwilling to raise concerns
- Lack of awareness of life/biography
- Lack of observation of triggers and heightened responses
- Lack of professional curiosity
- Passive use of policies and procedures
- Failure to gain views of others
- Lack of response to complaints
- Poor recording and communication between staff