

Safeguarding Adults Thresholds and Care Quality Concerns

Guidance for providers of social care and support across Surrey



1. Introduction

This guidance is to be used across Surrey to assist Providers of Social Care and Support to differentiate between care quality issues and safeguarding and provides alternative actions that can be considered.

This guidance should be used in conjunction with Providers own safeguarding policies and procedures. It is not a substitute for Providers following their own internal incident policies and processes and responding to practice and performance issues with staff or following agency disciplinary procedures.

Providers should always report safeguarding concerns in line with their organisation's policy. This guidance and any consultation are not a substitute for the decision the referrer needs to make when an individual has needs for care and support, is experiencing or is at risk of abuse or neglect, and whether as a result of those needs is unable to protect themself against abuse or neglect or the risk of it. Further information on this can be found in Surrey Safeguarding Adults Board Policy and Procedures.

If consultation is required in relation to quality or service contract monitoring, please contact the Quality Assurance Team (QAT). For decision making regarding safeguarding or quality concerns, please contact the Multi Agency Safeguarding Hub.

2. Quality and Safeguarding

The expectation is effective, high-quality care and support for every adult. If the quality of a service is reduced, adults using the service may be placed at risk. However, these concerns could indicate poor practice and poor quality care rather than abuse or neglect. This guidance contains examples of service provision issues frequently raised as safeguarding concerns that are quality issues and where alternative actions and notification to the Quality Assurance Team should be considered in the first instance.

3. Key Considerations

This guidance is for support when assessing and managing risks, and only contains some examples. You should always consider the individual circumstances of each situation and use your professional judgement when deciding on the best course of action.

Quality issues that are reported to the CQC or ICB Quality Team by Providers in Surrey should also be reported to the <u>ascquality.assurance@surreycc.gov.uk</u>.

4. Categories of Abuse and Neglect

Below are categories of abuse and neglect identified in the Care Act 2014, accompanied by illustrative examples of care quality issues that may not necessarily meet the safeguarding threshold. Additional categories and examples are provided on common incidents, such as

pressure ulcers, falls, medication errors, and interpersonal incidents among adults that are reported as safeguarding concerns but are care quality issues.

Neglect (and acts of omission)

| Description | Low / Quality care concern |
|--|---|
| An ongoing failure to meet someone's basic physical or psychological needs. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| Incidents relating to falls, pressure damage and medication concerns are addressed separately within this guidance document. | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: Appropriate care plan in place but care needs not fully met, such as incontinence needs not met on one occasion, but no impact or distress occurs. Missed home visit where there is no impact, and no other individual visits are missed. Incident of a person not supported with food/drink and reasonable explanation provided. A fall where no significant injury occurs, there are no other indicators of neglect, and action is taken to minimise further risk (see the falls section for further guidance). |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Advice and information provided. Review of existing care plans or creation of new care plans/risk assessments. Consideration for external additional services such as domestic support (e.g., Age UK). Referral to Surrey Fire Service for a home safety visit. Internal organisational training or other risk management processes. Complaints or disciplinary processes. |

Self-neglect

| Description | Low / Quality care concern |
|--|--|
| A person living in a way that puts their health, safety, or wellbeing at risk. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: Poor self-care causing some concern, but no signs of impact or distress. Property neglected but all essential services/appliances work. Risks can be managed by current professional oversight or universal services. The person is not at risk of losing their home, tenancy, or placement within the community. Evidence of low-level hoarding – low level impact on health/safety. No access to social care support. Occasional non-attendance at meetings, such as health appointments. |
| Alternative actions to consider | NOTIFY QUALITY ASSURANCE & COMMISSIONING |
| at every stage | Engagement with the person to consider options (e.g., domestic support/deep-clean) and/or any support network to consider alternative approaches. Referral to East or West Surrey Fire Service for a home safety visit. Referral to the local authority Adult Social Care department for an assessment or review. |

Physical abuse

| Description | Low / Quality care concern |
|---|--|
| The act of causing physical injury to someone else. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| Incidents relating to falls, pressure damage and medication concerns, and incidents between adults in a | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: |
| service are addressed separately within this guidance document. | Error by staff causing no or minor. injury (e.g., ill-fitting sling or unsuitable hoist/ transfer aid/ manual handling equipment is used). Light marking or bruising found which can be explained and where the person is not distressed. Appropriate moving and handling procedures not followed on a single occasion and with minimal or no impact caused. |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Advice and information provided. Review of existing care plans or creation of new care plans/risk assessments. Training and/or professional support and development. Share information with district nurse, GP, OT, or Falls Prevention Service. Complaints or disciplinary processes. |

Sexual abuse

| Description | Low / Quality care concern |
|--|--|
| When an adult is forced or persuaded to take part in sexual activities when they do not or cannot consent to this. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| This does not have to be physical contact and it can happen online. | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: Not committed by a Person in a Position of Trust (a person in a position of trust is an employee, volunteer, or student who works with adults with care and support needs), AND: • Incident of teasing or unwanted attention, either verbal or physical (but excluding genitalia), where the effect on the person is minimal and no distress is caused. Incident of teasing or low level unwanted sexualised attention (verbal or by gestures) directed at one adult by another whether capacity exists - no injury or distress caused. |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Information and education around safe sexual relationships and conduct. Share information with district nurse or GP for sexual advice or information. Referral to local authority Adult Social Care department for assessment. Review of existing care plans or creation of new care plans/risk assessments. |

Psychological abuse

| Description | Low / Quality care concern |
|--|--|
| Psychological or emotional maltreatment. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. |
| | Examples: |
| | Not committed by a Person in a Position of Trust (a person in a position of trust is an employee, volunteer, or student who works with adults with care and support needs), AND : |
| | Incident where a person is spoken to in a rude or inappropriate way – respect is undermined but no significant distress is caused. |
| | Occasional taunts or outbursts between two people using a service that do not cause impact or distress. |
| Alternative actions to consider | NOTIFY QUALITY ASSURANCE & COMMISSIONING |
| at every stage | Information and education around expected standards of conduct, respect, and dignity. Use of behavioural charts. |
| | Input from mediation services. Training around de-escalation and/or other risk management processes. |

Financial or material abuse

| Descripton | Low / Quality care concern |
|---|--|
| The unauthorised and improper use of funds, property, or any resources. This includes the use of theft, coercion, or fraud to obtain or try to obtain a person's money, possessions, or property. This type of abuse applies also to Lasting Power of Attorneys (LPAs). | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: |
| | Failure by relatives to pay care charges where no impact occurs, and the person receives personal allowance or has access to other personal monies. |
| | Incident of missing belongings, small amount of money where there is no indication of theft/abuse. |
| | Money is not recorded safely or properly but immediate actions have been taken to rectify this. |
| | Incident where a person is not involved in a decision about how their money is spent or kept safe, and concern is addressed. |
| | Unwanted cold calling/doorstep visits and Trading Standards notified. |
| Alternative actions to | NOTIFY QUALITY ASSURANCE & COMMISSIONING |
| consider at every stage | Advice and information provided. |
| , , | Procedures around "Property Inventory" and "Valuable Items Inventory." Lost and Found items. |
| | Communication with service user and their family or LPA. |

Organisational abuse

| Description | Low / Quality care concern |
|--|--|
| Neglect or poor professional practice or incidents due to the structure, policies, processes, or practices within an organisation, | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| resulting in ongoing neglect or poor care or lack of dignity or choice. | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: |
| | Incident of insufficient staffing but where there is no impact. |
| | Short-term lack of stimulation or opportunities to engage in meaningful social and leisure activities and where there is no impact. |
| | Care planning documentation is not person-centred or does not involve the person or capture their views. |
| | • Poor quality of care or professional practice that does not result in harm, albeit the person may be dissatisfied with service. |
| Alternative actions to | NOTIFY QUALITY ASSURANCE & COMMISSIONING |
| consider at every stage | Advice and information provided. |
| | Consultation with service user or next-of kin. |
| | Review of existing care plans or creation of new care plans/risk assessments. Training around de-escalation and/or other risk management processes. |
| | Quality Improvement Plan for the service |

Discriminatory abuse or hate crime

| Description | Low / Quality care concern |
|--|--|
| Ill-treatment experienced by people based on age, disability, gender, gender reassignment, marriage /civil partnership, pregnancy, maternity, race, religion and belief, sex, or sexual orientation. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: |
| | Not committed by a Person in a Position of Trust (a person in a position of trust is an employee, volunteer, or student who works with adults with care and support needs), AND : |
| | Incident when an inappropriate prejudicial remark is made to an adult and no distress is caused. |
| | Care planning that fails to address an adult's culture and diversity needs for a short period but where the issue(s) are being addressed. |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Information and education around expected standards of conduct, respect, equality, diversity, and inclusion. Training around conduct, respect, equality, diversity, and inclusion. Use of risk management processes. |

Pressure ulcers

| Description | Low / Quality care concern |
|---|---|
| Pressure ulcers are caused when an area of skin and the tissue below are damaged as a result of being placed under continuous | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| pressure sufficient to impair blood supply. | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. |
| | Examples: Single incident of Category 1 or 2 pressure ulcer. Category 3 & 4, unstageable and suspected deep tissue injury, or multiple Category 2 pressure ulcers where: • A care plan is in place. • Action is being taken. • Other relevant professionals are involved such as Tissue Viability Nurses. • There has been full discussion with the person, their family or representative. There are no other indicators of abuse or neglect or unexplained deterioration. |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Follow relevant internal policies and procedures. Refer to the NICE guidance on pressure ulcers (2014). Refer to the Pressure ulcers: how to safeguard adults - GOV.UK (www.gov.uk). Share information with district nurse or GP. Consideration of specialist support (e.g., Tissue Viability Nurses). |

Falls

| Description | Low / Quality care concern |
|--|--|
| Some people who are frail or have mobility problems may have a greater risk of falling. Following a fall, the individual may require | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| more intensive services for longer, and in some cases may never | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. |
| return to previous levels of mobility. A fall does not | Examples: |
| automatically indicate neglect and each individual case should be examined to understand the context of the fall. | A fall where no injury has occurred and: There is a reasonable explanation as to why this occurred. A care plan and/or risk assessment is in place and being adhered to. Actions are being taken to minimise further risk. Other relevant professionals have been notified. Full discussions with the person or people, next-of-kin, or any other representative. There are no other indicators of abuse or neglect. |
| Alternative actions to consider | NOTIFY QUALITY ASSURANCE & COMMISSIONING |
| at every stage | Follow relevant internal policies and procedures. Review and revise current care plans /risk assessments. For falls in older people refer to the NICE guidance (2013). Share information with the Falls Prevention Service or Occupational Therapy service. Share information with GP for any medical issues. |

Medication errors

| Description | Low / Quality care concern |
|--|--|
| Mismanagement /misadministration /misuse of drugs. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. |
| | Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. |
| | Examples: |
| | • Incidents where the person is accidently given the wrong medication, given too much or too little medication or given it at the wrong time but there has been no impact. |
| | Incidents where there is no impact but that has not been reported by staff members. |
| | Prescribing or dispensing error by GP, pharmacist or other medical professional resulting in no impact. • |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Review of relevant policies and procedures. Internal relevant training provided. Review of existing care plans or creation of new care plans/risk assessments. Complaints or disciplinary processes. |

Incidents between adults in a service

| Description | Low / Quality care concern |
|--|--|
| Any interaction involving two or more service users in any setting, involving physical, psychological/emotional, sexual, financial/material, or discriminatory behaviour (including verbal and threatening), which results in the risk of, or actual harm. | Lower-level concern where the threshold for a safeguarding enquiry is unlikely to be met. However, provider managers will be expected to notify the local authority Adult Social Care department with written record of what happened and what action was taken. Where there are several low-level concerns, consideration should be given as to whether the threshold may be met for a safeguarding enquiry due to increased risk. Examples: Incidents between people using a service where there is no apparent impact, and actions are undertaken to minimise the risk of reoccurrence. More than one incident where there is no apparent impact, and: A care plan and/or risk assessment is in place and is being adhered to Action is taken to minimise further risk. Other relevant professionals have been notified. There has been full discussion with the person, their next-of-kin, or their representative. No other indicators of abuse or neglect. |
| Alternative actions to consider at every stage | NOTIFY QUALITY ASSURANCE & COMMISSIONING Review of relevant policies and procedures. Internal relevant training provided. Review of existing care plans or creation of new care plans/risk assessments. Complaints or disciplinary processes. |