ADULTS AT RISK POLICY

Document Control

Classification:	
Author and Role:	Simon Boycott, Head of Development and Governance
Organisation:	Leeds General Practice Confederation Limited
Document Reference:	
Current Version Number:	1.4
Current Document Approved By:	Quality Committee
Date Approved:	25th July 2022
Review Date:	July 2024

C. Document Revision and Approval History

Version	Date	Version Created By:	Version Approved By:	Comments
0.1	09/08/2018	Leeds General Practice Confederation Limited	Leeds General Practice Confederation Limited	
1.0	19.10.18	LGPC	Wendy Pearson, Interim Director of Delivery	Changes to structure, format and content of policy to encompass LSAB guidance
1.1	7.11.18	LGPC	Wendy Pearson, Interim Director of Delivery	Minor changes to formatting and navigation references in document.
1.2	16.10.20	LGPC	Quality, Performance and Finance Committee	Minor changes to role and responsibilities to reflect team makeup, and minor changes to improve clarity/readability
1.3	11.1.22	Simon Boycott		Added governance section to include roles and responsibilities; Added sections on safe recruitment, training and PREVENT; Added reference to LSAB

				process to include PIPOT policy; Consolidate 'forms of abuse' and 'what is abuse' sections for clarity; Updated contact details including duty team.
1.4	3.5.22	Dave Kirby	Quality Committee	Addition of provisions to support workers in the raising of issues and escalating concerns following learning outcomes from a review.

Policy Statements

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The Confederation is committed to safeguarding adults at risk and this policy sets out the measures and processes we will put in place to achieve this. All individuals employed by or acting on behalf of the Confederation including volunteers are required to adhere to this policy

The document sets out the policy of the Confederation Limited in relation to the protection of vulnerable adults. Further guidance may be available on local inter-agency procedures via the Primary Care Organisation and / or Social Services.

The aims of the Confederation with regards to safeguarding adults risk 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 "Making Safeguarding Personal"
• To promote an outcomes approach in safeguarding that works for people resulting in the best experience possible

We will:
• Respond quickly and appropriately where abuse is suspected or allegations are made.
• Provide patients, their family and carers with the chance to raise concerns over their own care or the care of others.
• Have a system for dealing with, escalating and reviewing concerns.
• Remain aware of procedures to protect those at risk of abuse and maintain links with other bodies, especially local Safeguarding contacts.
• Leeds General Practice Confederation Limited will ensure that all staff are trained to a level appropriate to their role, In line with the – 'Adult Safeguarding: Roles and Competencies for Health Care Staff, First edition (August 2018)[1]'

Governance

The **Executive** has overall responsibility to ensure that the organisation complies with its obligations to take appropriate measures to ensure that those who use services are safe from harm. The **Chief Executive** enacts this duty and delegates certain roles and duties within the organisation to ensure these responsibilities and obligations are met:

The **Safeguarding Lead** for the Confederation is Stephanie Lawrence (Director of Nursing and Allied Health Professionals) and is responsible for ensuring that the Confederation has appropriate policies

[1] https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/august/pdf-007069.pdf?la=en

and procedures for Safeguarding in place, and that they are complied with. The Safeguarding Lead also provides advice and guidance to staff in matters of Safeguarding.

The **Lead GP for Safeguarding** in Confederation clinical services is Dr Dave Kirby (Medical Lead for Extended Access Services). The Lead GP supports the Safeguarding Lead in their duties by ensuring that Confederation policies and procedures are followed in Confederation clinical services where direct care is provided.

The **Quality Committee** leads on assurance of Safeguarding in Confederation services and is delegated by the Executive to seek assurance from the Safeguarding Lead, Lead GP for Safeguarding, and heads of service through key performance indicators and reports that standards are being met and policy is complied with, and to provide assurance of the same to the Executive and Strategic Board. Dr Ruth Burnett (Medical Director) is the Chair of the Quality Committee.

Policy Definitions

Who is an adult at risk?

The definition is wide, however this may be regarded as anyone over the age of 18 years who may be unable to protect themselves from abuse, harm or exploitation, which may be by reason of illness, age, mental illness, disability or other types of physical or mental impairment.

For the purposes of this policy and in accordance with the Care Act 2014, an adult at risk an adult who:

- is aged 18 years or more, and
- has needs for care and support (whether or not these are currently being met),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Such a definition includes adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen e.g. whether present from birth or due to advancing age, chronic illness or injury.

Also included are people with a mental illness, dementia or other memory impairments, people who misuse substances or alcohol. Those at risk may live alone, be dependent on others (care homes etc.), elderly, or socially isolated. Those who lack capacity to protect themselves from harm are also included in this policy's definition of adults at risk.

What is abuse?

Abuse can take many forms and the circumstances of the individual should always be considered. It may consist of a single act or repeated acts. The following are examples of issues that would be considered as a safeguarding concern.

Physical abuse - includes hitting, slapping, pushing, kicking, misuse of medication, unlawful or inappropriate restraint, or inappropriate physical sanctions.

Domestic abuse – is "an incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse… by someone who is or has been an intimate partner or family member regardless of gender or sexuality" (Home Office, 2013). Domestic violence and abuse may include psychological, physical, sexual, financial, emotional abuse; as well as so called 'honour' based violence, forced marriage and female genital mutilation (please refer to the Confederation Safeguarding Children Policy for definitions and guidance around FGM).

Sexual abuse - includes rape and sexual assault or sexual acts to which the adult at risk has not consented, or could not consent or was pressured into consenting.

Psychological abuse - includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal from services or supportive networks.

Financial and material abuse – includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Modern slavery - includes human trafficking, forced labour and domestic servitude. Traffickers and slave masters use the means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhuman treatment.

Neglect and acts of omission - includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Discriminatory abuse - includes abuse based on a person's race, sex, disability, faith, sexual orientation, or age; other forms of harassment, slurs or similar treatment or hate crime/hate incident.

Organisational abuse – includes neglect and poor practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Self-neglect - covers a wide range of behaviours, such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviours such as hoarding.

Abuse may be deliberate or as a result of lack of attention or thought, and may involve combinations of all or any of the above forms. It may be regular or on an occasional or single event basis, however it will result in some degree of suffering to the individual concerned. Abuse may also take place between one vulnerable adult and another, for example between residents of care homes or other institutions.

A safeguarding response in relation to self-neglect may be appropriate where:

- a person is declining assistance in relation to their care and support needs, and
- the impact of their decision, has or is likely to have a substantial impact on their overall individual wellbeing

Indications

Indications of abuse can be, but are not limited to:

- Bruising
- Burns
- Falls
- Apparent lack of personal care
- Nervous or withdrawn
- Avoidance of topics of discussion
- Inadequate living conditions or confinement to one room in their own home
- Inappropriate controlling by carers or family members
- Obstacles preventing personal visitors or one-to-one personal discussion
- Sudden changes in personality
- Lack of freedom to move outside the home, or to be on their own
- Refusal by carers to allow the patient into further care or to change environs
- Lack of access to own money
- Lack of mobility aids when needed

Preventing Radicalisation

Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit.

We will work to ensure that, where there are signs that someone has been or is being drawn into terrorism, our staff are trained to recognise those signs correctly and are aware of and can locate available support.

Preventing someone from being drawn into terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence.

We will train staff to the standards set out in ‘Adult Safeguarding: Roles and Competencies for Health Care Staff, First edition (August 2018)’ and ensure that training is updated in line with this guidance.

We will ensure that our Safeguarding policies and processes follow the principles set out in ‘Building Partnerships, Staying Safe: The health sector contribution to HM Government’s Prevent strategy: guidance for healthcare organisations (November 2011)’.

Responsibilities of all employees, workers, and volunteers

The identification and escalation of safeguarding concerns remains everyone's responsibility. In line with this policy, on suspicion or identification of safeguarding concerns, the referral to adult safeguarding services should be initiated as outlined in this policy.

If however, in the exceptional circumstance, where something was noted to be unusual or raise a vague suspicion that something deeper may exist and you did not feel it reached the threshold to seek advice from the city's safeguarding services, you must still ensure you act. This may be to discuss the case with the Confederation's safeguarding lead or potentially the practice's safeguarding lead if felt more appropriate. It would however, be usual practice to escalate any concerns to the city wide safeguarding team and any decision not to do this must be clearly documented within the medical record.

On receipt of a request to discuss a safeguarding issue within the service, it is the responsibility of the Safeguarding Lead or Deputy to record a DATIX for the purpose of reporting and any required investigation/action.

If any team member or volunteer has reason to believe that abuse, including self-neglect, is or may be taking place you have a responsibility to act on this information. It does not matter what your role is, doing nothing is not an option.

If a person discloses abuse to you directly, use the following principles to respond to them:

- Assure them that you are taking the concerns seriously
- Do not be judgemental or jump to conclusions
- Listen carefully to what they are telling you, stay calm, get as clear a picture as you can. Use open ended questions
- Do not start to investigate or ask detailed or probing questions
- Explain that you have a duty to tell your manager or the designated officer
- Reassure the person that they will be involved in decisions about them

Your responsibilities are:

1. To take action to keep the person safe if possible.

    - Is an urgent police presence required to keep someone safe – call 999
    - Does the person need urgent medical assistance, do they need an ambulance – call 999

2. If a crime has occurred, be aware of the need to preserve evidence

3. Always inform your organisations Safeguarding Lead. You cannot keep this information secret, even if the person asks you to.

4. Clearly record what you have witnessed or been told, record your responses and any actions taken.

Team members must not delay making a safeguarding referral where there is a concern but they should make their Safeguarding Lead aware of the referral or intention to refer at the earliest opportunity. Team members who need to raise a Safeguarding Concern urgently should follow Flow chart 1 – Managing Safeguarding Concern.

Staff Employment & Training

Safe Recruitment

Sometimes there are people who work, or seek to work with adults at risk of harm who may pose a risk to them and who may harm them. In order to reduce the risk of this we will do the following:

- Use a rigorous process to assess the candidate's suitability for the role which includes:
- Making clear our commitment to safeguarding and protecting adults at risk of harm
- Having a face-to-face or virtual interview with pre-planned and clear questions
- Verification during the application process whether they have any criminal convictions, cautions, other legal restrictions or pending cases that might affect their suitability to work in the post they have applied for
- Check the candidate actually holds any relevant qualifications they say they have
- Apply for a DBS check for all staff that have contact with adults at risk of harm. Candidates with a clear DBS check dated within the last 6 months will not require a new DBS check.
- Always check any references candidates provide.
- Check the candidate's identity by asking for bring photographic ID.
- Provide new employees with a copy of our safeguarding procedures.

There may be occasions where we wish to appoint a worker from abroad. This will mean that DBS checks may not be able to be undertaken. In these cases we will establish whether a "fit person" check may be available from the country the person is moving from. We will ensure that additional references are undertaken on any worker from abroad.

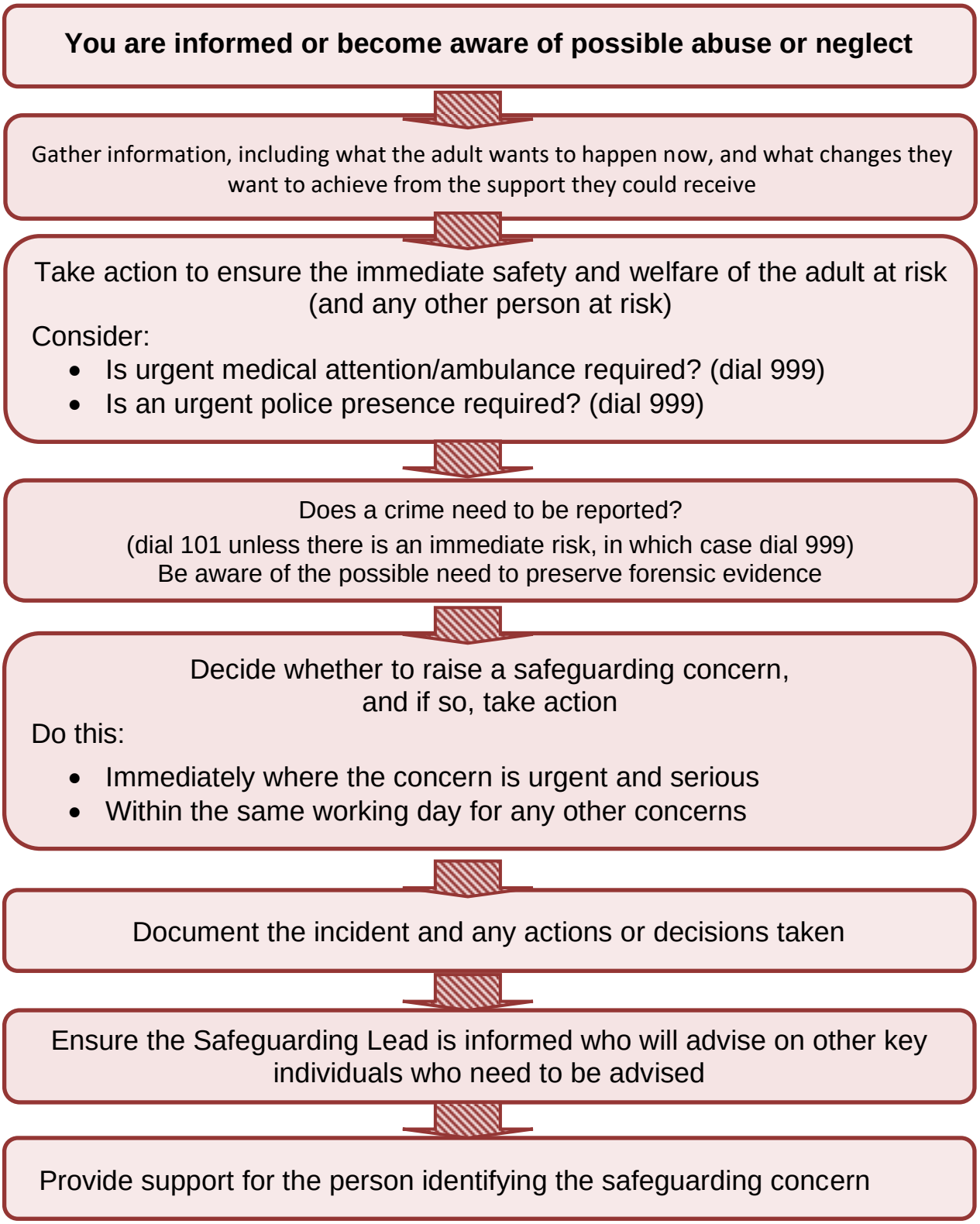
Staff training

We will ensure that all of our staff are trained to the standards set out in 'Adult Safeguarding: Roles and Competencies for Health Care Staff, First edition (August 2018)' and that training is updated in line with this guidance.

The training and competencies of all staff will be recorded, monitored and maintained as part of the employee records.

Flow Chart 1 – Managing a Safeguarding Concern

Raising a safeguarding concern means reporting abuse to the local authority under the safeguarding adults procedure. Anyone can raise a safeguarding concern and team members raising a concern should follow this procedure:



Additional Guidance:

A. Considering whether to Raise a Safeguarding Concern

When deciding whether a safeguarding concern should be raised, consider the following key questions:

1. Is the person an 'adult at risk' as defined within this policy/procedure?

2. Is the person experiencing, or at risk of, abuse and neglect?

3. What is the nature and seriousness of the risks?

Consider:

- The person's individual circumstances
- The nature and extent of the concerns
- The length of time it has been occurring
- The impact of any incident
- The risk of repeated incidents for the person
- The risk of repeated incidents for others

4. What does the adult at risk want to happen now?

Wherever possible, consider what the adult at risk wants to happen next, what do they want to change about their situation, and what support do they want to achieve that.

On some occasions, it may be necessary to raise a safeguarding concern even if this is contrary to the wishes of the adult at risk. Any such decision should be proportional to the risk, for example:

- It is in the public interest e.g. there is also a risk to others, a member of staff or volunteer is involved, or the abuse has occurred on property owned or managed by an organisation with a responsibility to provide care
- The person lacks mental capacity to consent and it is in the person's best interests
- The person is subject to coercion or undue influence, to extent that they are unable to give consent
- It is in the person's vital interests (to prevent serious harm or distress or life threatening situations)

If you remain unsure whether to raise a safeguarding concern, you can:

- Refer to the Decision Support Tool for Raising Safeguarding Concerns in Appendix 2
- Contact your organisations safeguarding adults lead for advice
- Seek advice from Adult Social Care, 0113 222 4401
- Refer to the Multi-Agency Safeguarding Adult Policy and Procedures at https://leedssafeguardingadults.org.uk/safeguarding-adults/multi-agency-policy-and-

procedures for further information and guidance, in particular the guidance on managing concerns with Persons in a Position of Trust in section 11.4 of the guidance.

B. Considering whether to report a concern to the police

If a crime has been or may have been committed, seek the person's consent to report the matter immediately to the police. This will be in addition to raising a safeguarding concern with the local authority.

If the person has mental capacity in relation to the decision and does not want a report made, this should be respected unless there are justifiable reasons to act contrary to their wishes, such as:

- the person is subject to coercion or undue influence, to the extent that they are unable to give consent, or
- there is an overriding public interest, such as where there is a risk to other people
- it is in the person's vital interests (to prevent serious harm or distress or in life- threatening situations)

There should be clear reasons for overriding the wishes of a person with the mental capacity to decide for themselves. A judgement will be needed that takes into account the particular circumstances.

If the person does not have mental capacity in relation to this decision, a 'best interests' decision will need to be made in line with the Mental Capacity Act. The rationale for any 'best interests' decision made against an individual's wishes MUST be clearly recorded in the patients' medical record.

<u>Preserving evidence</u>

If a crime has occurred, try to preserve evidence in case there is a criminal investigation.

- try not to disturb the scene, clothing or victim if at all possible
- secure the scene, for example, lock the door, if possible,
- preserve all containers, documents, locations, etc.
- evidence may be present even if you cannot actually see anything
- if in doubt, contact the police and ask for advice

The police should be contacted for advice wherever required.

C. Who else to inform

You may also need to inform:

- relatives of the adult at risk according to their wishes, or in their 'best interests' where they lack the mental capacity to make this decision for themselves
- those with lasting power of attorney for health and welfare of the adult at risk
- child safeguarding services, if children are also at risk from harm

- your Human Resources Manager or appropriate member of the Confederation Executive if allegations/concerns relate to a member of employee or volunteer
- staff delivering a service on a need-to-know basis so that they do not take actions that may prejudice an enquiry

D. Document the concern and any actions or decisions taken

Ensure all actions and decisions are fully recorded. It is possible that your records may be required as part of an enquiry, be as clear and accurate as you can. Record the reasons for your decisions and any advice given to you in making these decisions.

Ensure that appropriate records are maintained, including details of:

- the nature of the safeguarding concern/allegation
- the wishes and desired outcomes of the adult at risk
- the support and information provided to enable the adult at risk to make an informed decision
- assessments of Mental Capacity where indicated
- the rationale for raising a concern or not

E. How to make a Raise a Safeguarding Concern:

To raise a safeguarding concern under the safeguarding adults procedures:

Contact:

- Adult Social Care Contact Centre: 0113 222 4401
- Emergency Duty Team: 0113 378 0644 (if urgent and outside of the Contact Centre times)

The person you speak to will ask you for details about the allegation/concern. If you have reported the incident to the police, tell the person this as well.

Then complete a referral form (see Appendix 1).

The safeguarding concern will be allocated to an appropriate team, who may then contact you to discuss the concerns further and advise you as to the process they will need you to follow.

CONTACT LIST	
To raise a safeguarding concern or seek advice	
Leeds Adult Social Care: Contact Centre Emergency Duty Team (Outside of the contact centre times above)	Tel: 0113 222 4401 Tel: 0113 378 0644
Contacting the police	
If the person is in imminent danger If you need to report a crime, but the person is not in imminent danger	Tel: 999 (Emergency Service) Tel: 101 (Non-Emergency Service)
Employment related advice lines	
Disclosure and Barring Service (DBS)	Tel: 03000 200 190
Whistleblowing advice services	
Mencap www.mencap.org.uk/organisations/whistleblowing-helpline	Helpline: 0808 808 1111
Care Quality Commission: www.cqc.org.uk/contact-us	Tel: 03000 616161
Public Concern at Work www.pcaw.org.uk	Tel: 020 7404 6609.
Advocacy services	
Advonet www.advonet.org.uk	Tel: 0113 244 0606

Safeguarding Adults Concern

Supporting Information

To Raise A Safeguarding Adult Concern contact: **Adult Social Care Contact Centre** on **0113 222 4401** (Monday-Friday 8am-6pm) (Textphone for deaf and hard of hearing people: 0113 222 4410).

Where urgent and outside of these hours ring the Emergency Duty Team on 0113 240 9536.

You will be asked for details about the concern. A worker from the appropriate team will then contact you to discuss the concerns and advise you to whom this Supporting Information form should be sent.

Please complete this form with as much information as possible.
Leave blank those questions you are unable to answer.

Date Safeguarding Concern Raised:	

1. Who is the Adult At Risk?

ESCR/CIS ref (If known):

Title: Mr/Mrs/Ms/Other*	First Name(s):	Surname:	Date of Birth: Age:
Address: Post Code: Tel:		NHS Number (if known):	
		Date of Death (if applicable):	
		Gender:	
		Language spoken:	
		Ethnicity:	
		Religion:	
		Marital status:	

Primary Support Reason:

Physical support needs ☐ (exc. sensory support needs)	Mental health support needs ☐ (excluding dementia)	Support for learning disability ☐
		Support for substance misuse ☐
Sensory support needs ☐	Support with memory / cognition ☐ (including dementia)	Other (please specify below) ☐ _____
Carer support needs ☐		

Record details of their Professional Support Network (e.g. GP, District Nurse, CPA Coordinator, Social Worker)

Name	Organisation	Contact Details

2. What existing care/support services is the person receiving (if any)?

3. Details of the alleged incident

(A) Describe what has happened, when and where. (B) What are the adults at risk's views on the incident (C) Describe any injuries or harm experienced by the adult at risk
Please tick here if a Body Map has been completed ☐

Type(s) of abuse					
Physical	☐	Domestic abuse	☐	Financial / Material	☐
Neglect / Acts of omission	☐	Discriminatory	☐	Organisational	☐
Psychological	☐	Sexual abuse	☐	Self-Neglect	☐
Modern slavery	☐	Sexual exploitation	☐	Tick all that apply	

4. What does the adult at risk want to happen now?

4a. What are the desired outcomes of the adult at risk? That is, what do they wish to achieve from the support they might receive, such as feeling safe at home or having no contact with certain individuals

Has the adult at risk given consent for the concerns to be raised with the local authority safeguarding services?	☐ Yes ☐ No ☐ Not Sure
Has an assessment of mental capacity been undertaken?	☐ Yes ☐ No ☐ Not Sure
Is the safeguarding concern being raised in the best interests of the adult in line with the Mental Capacity Act?	☐ Yes ☐ No ☐ Not Sure

5. Actions taken in relation to the safeguarding concerns?

Details of action taken:		
Have the police been informed?	☐ Yes ☐ No	Crime Ref. Number:
Has medical intervention been sought?	☐ Yes ☐ No	From where/whom?

6. Details of the person or organisation alleged to have caused harm

Name:		Date of Birth:	
Address: Post Code:		Gender:	
		Does the person/organisation know that a safeguarding allegation has been made? ☐ Yes ☐ No ☐ Not Sure	
What is their relationship to adult at risk?		Is this person also an adult at risk? ☐ Yes ☐ No	

Are they known to the adult at risk? ☐ Yes ☐ No	
Additional information, such as previous concerns:	

7. Any other relevant information
Include any safety or confidentiality issues that may impact on how the concern is acted upon

8. Details of the person completing this form			
Name:		Job Title:	
Address: Post Code:			
Tel:		Date:	

Appendix 2: Decision support tool for making safeguarding alerts

The decision support tool is provided as a support and not a replacement for professional decision making. It should used alongside other guidance provided and with consideration of the specific unique circumstances of the allegation or concern.

Types of Abuse/ Types of Response	**Examples: Where raising a safeguarding concern may not be required** Consider Alternatives - disciplinary, complaints, incident/serious incident processes, training etc.	**Examples: Where raising a safeguarding concern is likely to be required**
Physical	One service user 'taps' or 'slaps' another but not with sufficient force to cause a mark or bruise and the victim is not intimidated. Isolated incident, care plans amended to address risk of reoccurrence Or One service user shouts at another in a threatening manner, but the victim is not intimidated. Care plans amended to address risk of reoccurrence.	Predictable and preventable (by staff) incident between two adults at risk resulting in harm Harm may include: bruising, abrasions and/or emotional distress caused
	Adult at risk has been formally assessed under the Mental Capacity Act. Actions taken in best interests are not the 'least restrictive'. Harm has not occurred and actions are being taken to review care plans. Application for Deprivation of Liberty Safeguards may be required.	An unauthorised deprivation of liberty results in a form of harm to the person or authorisation has not been sought for DoLS despite this being drawn to the attention of hospital/care home Harm may include: loss of liberty, rights and freedom of movement. Other types of abuse may be indicated – psychological/emotional distress
Psychological / Emotional	The adult at risk is spoken to once in a rude, insulting and belittling or other inappropriate way by a member of staff or family carer. Respect for them and their dignity is not maintained but they are not distressed. Actions being taken to prevent reoccurrence.	Isolated incident(s) resulting in harm or recurring event, or is happening to more than one adult at risk. Harm may include: distress, demoralisation, loss of confidence or dignity. Insults contain discriminatory elements e.g. racist or homophobic abuse
Neglect and acts of omission	Isolated incident of a person not receiving necessary help to have a drink/meal and a reasonable explanation is given. Actions being taken to prevent reoccurrence.	Recurring event resulting in harm, or is happening to more than one adult at risk. Harm may include: hunger, thirst, weight loss, constipation, dehydration, malnutrition, tissue viability issues, loss of dignity
	Isolated incident where a person does not receive necessary help to get to the toilet to maintain continence, or have appropriate assistance with changing incontinence pads and a reasonable explanation is given. Action being taken to prevent reoccurrence	Isolated incident(s) resulting in harm or recurring event, or is happening to more than one adult at risk. Harm may include: pain, constipation, loss of dignity and self-confidence, skin problems
	Patient has not received their medication as prescribed. Appropriate actions being addressed to prevent reoccurrence.	Isolated incident(s) resulting in harm or recurring event, or is happening to more than one adult at risk. Inappropriate use of medication that is not consistent with the person's needs Harm may include: pain not controlled, physical or mental health condition deteriorates/kept sleepy/unaware; side effects
	Appropriate moving and handling procedures are not followed or the staff are not trained or competent to use the required equipment but the patient does not experience harm. Action plans are in place to address the risk of harm.	The person is injured or action is not being taken to address a risk of harm. Harm may include: injuries such as falls and fractures, skin damage, lack of dignity

Neglect and acts of omission	The 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	Isolated incident(s) resulting in harm or recurring event, or is happening to more than one adult at risk. Harm may include: missed medication and meals, care needs significantly not attended to.
	Person is discharged from hospital without adequate discharge planning, procedures not followed, but no harm occurs. Lessons being learned to improve practice.	The adult at risk is discharged without adequate discharge planning, procedures not followed and experiences harm as a consequence. Harm may include: care not provided resulting in deterioration of health or confidence, avoidable readmission to hospital.
	Adult at risk is known to be susceptible to pressure ulcers has not been formally assessed with respect to pressure area management, but no discernable harm has occurred. Actions being taken to prevent a future incident reoccurring.	Person has not been formally assessed/advice not sought with respect to pressure area management or plan exists but is not followed, in either case harm is incurred Harm may include: avoidable tissue viability problems
	Person does not have within their care plan/service plan/treatment plan a section that addresses a significant assessed need such as: • Management of behaviour to protect self or others • Liquid diet because of swallowing • Cot sides to prevent falls and injuries However, no harm occurs and actions being taken to address.	Failure to specify in a person's plan how a significant need must be met and action or inaction related to lack of care planning results in harm, such as injury, choking etc. A risk of harm has been identified but is not acted upon in a robust and proportionate way or there is a failure to take reasonable actions to identify risk. As a consequence one or more persons are placed at an avoidable repeated risk of harm.
	The adult at risk's needs are specified in a treatment or care plan. Plan not followed, needs not met as specified but no harm occurs.	Failure to address a need specified in a person's care plan or failure to act on an identified risk, results in harm.
Sexual	Isolated incident of teasing or low level unwanted sexualised attention (verbal or non-intimate touching) directed at one service user to another, whether or not they have mental capacity. Care plans being amended to address. Person is not distressed or intimidated.	Intimate touch between service users without valid consent or recurring verbal sexualised teasing resulting in harm Harm may include: emotional distress, intimidation, loss of dignity
Discriminatory	Adult at risk 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/requested medical attention in a timely fashion.	Adult at risk is provided with an evidently inferior medical service or no service as a result of discriminatory attitudes/actions. Harm may include: pain, distress and deterioration of health
Financial and material	Staff member has borrowed items from service users with their consent, professional boundaries breached, but items are returned to them. Actions being taken to prevent reoccurrence	Isolated or repeated incidents of exploitation relating to benefits, income, property, will. Theft by a person in a position of trust, such as a formal/informal carer
Organisational	Care planning documentation is not person centred or there are few opportunities to engage in social and leisure activities, but harm is not occurring. Actions being taken to address	Rigid inflexible routines, or lack of stimulation resulting in harm Harm may include: impairment/deterioration of physical, intellectual, emotional or social development or health; loss of person dignity
		There are systemic reasons for any form of abuse i.e. the way a service is provided significantly contributes to any harm/abuse experienced (or creates a risk of harm/abuse occurring).

Please Note: Abuse can take many forms. The types of abuse listed here are just examples. Domestic abuse, modern slavery and self-neglect would also be considered forms of abuse.