Dr James Hamilton-Smith & Partners

Safeguarding Policy

*This policy recognises the legal framework for protecting children contained in 'Working Together to Safeguard Children (2015)' and for Adults in the 'Care Act (2014)' and the 'Female Genital Mutilation Act (2003)'. It directly addresses Regulation 13 of the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014', and specifies the requirements for service users from abuse and improper treatment and shows how we will work in partnership with other organisations to safeguard patients.*

## Purpose

The purpose of this policy and its related statements is to provide a structure for the delivery of high quality, safe care in accordance with legislation. This policy must be followed by all team members and by others involved in delivering care to our patients. The practice policy statements are supported by further information, training, monitoring and review to equip our team to implement these policies (see Appendix 1).

## Policy Statement

It is the policy of the Dr James Hamilton-Smith & Partners to make every effort to safeguard children and vulnerable adults from physical, sexual and emotional harm while on our premises. The practice takes all reasonable steps to ensure that, through relevant procedures and training, children, young people and adults using our services receive safe, high quality care.

This practice adopts a zero tolerance approach to abuse and will:

» Protect children and vulnerable adults, in our care, from abuse and improper treatment (as defined in Appendix 7).

» Provide a course of action if abuse is suspected.

» Ensure that patient's informed consent for procedures is gained.

As health professionals, we have a duty to share information if by doing so someone is kept safe. (Statutory Guidance can be found in "Working Together 2015").

## Scope

All Staff.

Anyone involved in delivering or supporting the provision of care to our patients.

## Accountability

The Registered Provider is responsible for ensuring the practice's policies and procedures are fit for purpose, well communicated and consistently observed.

The Registered Manager and appointed Child Safeguarding Lead and Vulnerable Adult Protection Lead are responsible for responding in-line with practice policy to all safeguarding concerns. They will implement induction training, regular team training and performance appraisals. They are also responsible for policy audit, review and updating (see Appendix 2 and 3).

All health professionals have a duty to raise any safeguarding concerns if by doing so someone will be kept safe. (Statutory Guidance can be found in "Working Together 2015").

## Policy Introduction

Safeguarding children and vulnerable adults is everyone's responsibility. This policy meets legislative requirements for Safeguarding and defines minimum standards for training, monitoring and updating our practice's policy and procedures.

The policy aims to ensure that:

» Staff can recognise signs of potential abuse, neglect, bullying and harassment.

» Patients are involved in risk assessments and decision-making about their treatment.

» Staff understands the requirements of the Mental Capacity Act 2005, the Female Genital Mutilation Act 2003 and guidance in relation to vulnerable adults.

» Staff understands the difference between lawful and unlawful restraint.

Service users must be protected from abuse and improper treatment. This practice will clearly define and operate the following systems and processes to prevent abuse of service users:

» Investigation of any allegation or evidence of abuse or improper treatment;

» An Equality and Diversity Policy;

» Staff Induction Programmes and Training;

» Pre-employment Enhanced Disclosure and Barring Service (DBS) checks and references are checked before a new member of staff begins work at the practice;

» Police will be notified if a member of staff behaves in a way that places children or vulnerable adults at risk;

» Conduct Risk Assessments;

» Conduct Mental Capacity Assessments;

» Conduct Significant Event Analysis;

» Conduct Policy Audits and Reviews;

» Responding if it is suspected that people are being exploited, radicalised or drawn into terrorism, undergone or about to undergo Female Genital Mutilation (FGM).

The practice will not:

» Discriminate on the grounds of any Protected Characteristics of the Equality Act 2010;

» Perform acts intended to restrain an adult or vulnerable adult that are not necessary to prevent harm;

» Be degrading to children and vulnerable adults;

» Disregard the care needs of children or vulnerable adults.

## Procedures for Safeguarding Safeguarding Vulnerable Adults

A Vulnerable Adult is defined as "a person ages 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of themselves or unable to protect themselves against significant harm or exploitation" (Law Commission for England and Wales (1995) Mental Capacity Report No. 231, London:

HMSO).

If you have any concerns or a patient is a risk, report this to the Registered Provider and/or Registered Manager

of Safeguarding Vulnerable Adults Lead (see Appendix 3).

If you have any concerns about Female Genital Mutilation (FGM) or a patient is at risk, report this to the Police.

It is good practice to explain your concerns to the vulnerable adult and carers, informing them of your intention to refer and seek their consent - being open and honest from the start, this results in better outcomes. Do not, however discuss your concerns with the carer where:

» The discussion might put the patient at greater risk;

» The discussion would impede police investigation or social work enquiry;

» Sexual abuse by family members, or organised or multiple abuse is suspected;

» Fabricated or induced illness is suspected;

» Patients or carers are being violent or abusive and discussion would place you or others at risk;

» It is not possible to contact parents or carers without causing undue delay in making the referral.

## Procedure for staff if abuse or neglect is suspected Ask yourself:

» Could the injury have been caused accidentally? If so, how?

» Does the explanation for the injury fit the age and clinical findings?

» If the explanation of the cause is consistent with the injury, is this itself within the normally acceptable limits of behaviour?

» If there has been any delay in seeking advice, are there good reasons for this?

» Does the story of the accident vary?

## Observe:

» The relationship between the parent/carer and vulnerable adult;

» The vulnerable adult's reaction to other people;

» The vulnerable adult's reaction to examinations;

» Any comments made by the vulnerable adult or parent/carer that give concern about the vulnerable adult's upbringing or lifestyle.

In the first instance, discuss your concerns with the safeguarding lead, Dr James Hamilton-Smith. If you remain concerned, informal advice could be sought first from your local services without disclosing the vulnerable adult's name. This will help you decide whether you should make a formal referral.

Where there is serious physical injuring arising from suspected abuse:

» Refer the individual to the nearest hospital A&E department, with the consent of the person having parental responsibility or care of the vulnerable adult;

» Advise the A&E department in advance that the patient is being sent;

» If consent is not obtained, contact the duty social worker at the local Social Services Department or the

police, so that action can be taken to safeguard the welfare of the individual.

## Procedures for Safeguarding Children

If you have any concerns or believe a child to be at risk of neglect or abuse, report this to the Registered Provider and/or Registered Manager or Child Safeguarding Lead.

If you have any concerns about Female Genital Mutilation (FGM) or a child is at risk, report this to the Police.

It is good practice to explain your concerns to the child and parents/carers, informing them of your intention to refer and seek their consent - being open and honest from the start, this results in better outcomes. Do not, however discuss your concerns with the parents/carers where:

» The discussion might put the patient at greater risk;

» The discussion would impede police investigation or social work enquiry;

» Sexual abuse by family members, or organised or multiple abuse is suspected;

» Fabricated or induced illness is suspected;

» Patients or carers are being violent or abusive and discussion would place you or others at risk;

» It is not possible to contact parents or carers without causing undue delay in making the referral.

## Procedure for staff if abuse or neglect is suspected Ask yourself:

» Could the injury have been caused accidentally? If so, how?

» Does the explanation for the injury fit the age and clinical findings?

» If the explanation of the cause is consistent with the injury, is this itself within the normally acceptable limits of behaviour?

» If there has been any delay in seeking advice, are there good reasons for this?

» Does the story of the accident vary?

## Observe:

» The relationship between the parent/carer and child;

» The child's reaction to other people;

» The child's reaction to examinations;

» Any comments made by the child or parent/carer that give concern about the child's upbringing or lifestyle.

When having a conversation with a child in which they make a disclosure about abuse:

» It is important to not ask leading questions;

» It is also important not to agree to keep it secret;

» It must be made clear to the child that anything they say to a professional will be kept confidential but at

any point they may share something that poses a risk to the safety of the child or that of anyone else.

In the first instance, discuss your concerns with the safeguarding lead, Dr James Hamilton-Smith. If you remain concerned, informal advice could be sought first from your local Social Services without disclosing the child's name. This will help you decide whether you should make a formal referral.

It is good practice to explain your concerns to the child and parents, informing them of your intention to refer and seek their consent - being open and honest from the start, results in better outcomes for the children. Do not, however discuss concerns with the parents where:

» The discussion might put the child at greater risk;

» The discussion would impede police investigation or social work enquiry;

» Sexual abuse by family members, or organised or multiple abuse is suspected;

» Fabricated or induced illness is suspected;

» Parents or carers are being violent or abusive and discussion would place you or others at risk;

» It is not possible to contact parents or carers without causing undue delay in making the referral.

If you remain concerned, seek informal advice from the local Social Services Department without disclosing the patients name to help you decide whether a formal referral is needed. Contact details are as follows:

» When physical signs lead to suspicions of abuse firstly, make enquiries with the parents to try to get a picture about home life or about the parenting they receive.

» When injuries are observable, enquire about them to both parents and the child and ask if they have sought medical advice. If it's a huge suspicious injury and you feel the child is at immediate danger then call the police. As health professionals we have a duty to share information if by doing so someone is kept safe. (Statutory Guidance can be found in "Working Together 2015").

» When a Safeguarding Lead refers someone on they are enabling more qualified people to interpret the information they have gathered and make a best interest's decision. The child or vulnerable adult needs a voice, as healthcare professionals and members of society we have a duty to give them that (see Appendix 5).

## Training and CPD

Training in safeguarding procedures will be beginning in the new staff induction programme. This will also include significant event analysis training. The practice will provide clear lines and methods of reporting incidents and concerns and ensure ongoing training ensures all team members know how to meet their safeguarding responsibilities.

The objective of this training will be to enable staff to:

» **Competence** - Have the required knowledge and confidence to carry out their safeguarding responsibilities.

» **Control** - Roles and responsibilities will be allocated through the team.

» **Cooperation** - Internal and interagency cooperation and communication processes will be agreed and the team will be able to put them into action immediately when necessary.

» **Communication** - Record keeping must be sufficiently detailed for a reflective significant event analysis to following a critical incident (see Appendix 6).

## Continuous Professional Development

All GMC registered staff will participate in 2 hours CPD training per year. The Safeguarding Lead will undertake refresher training biannually.

All staff trained in Safeguarding Children and Adults, refresher training every 3 years.

## Principles of Consent

We recognise that informed consent can only be obtained when the patient has sufficient information, in a format they understand, to enable them to make an assessment of the risks and benefits linked to the available treatment options.

We accept that patients have the right to choose whether or not to accept advice or treatment. Consent is required before starting treatment of physical investigation. That consent must be:

» Informed;

» Voluntary;

» Within the patient ability to make an informed decision.

We recognise that getting consent is a process, not a one off event.

It will be part of an ongoing discussion between our health professionals and our patients.

We will find out what patients want to know as well as telling them what we think they need to know. We will ensure patients are fully aware of:

» The nature of the contract, and in particular whether the patient is being accepted for treatment under the NHS or privately;

» The charges for the initial consultation and probably costs of further treatment.

We will assess individual patients' communication needs and provide additional resources required to optimise their ability to fully understand the need for proposed treatments as well as the risks and benefits (see Appendix 4).

## Clinical Audit

The audit process will provide objective information to assess the overall success of this policy and the levels of compliance. A regular, planed review schedule has been set to cover all practice policies. Change is constant and inevitable. Audit and review processes will be used to ensure that systems and their implementation remain valid and relevant. Our review and audit process will involve all user who will be consulted before changes are made.

The following aspects of this policy will be subjected to regular clinical audit processes including:

» Clear lines of reporting;

» Documented systems and procedures;

» Regular team training and Governance sessions;

» Requirements for team CPPD activities;

» Recording adverse incidents;

» Implementing a confidential process to report concerns about risks to patients.

# Appendix 1

## Safeguarding Children and Vulnerable Adults Implementation and Maintenance Plan

This action plan aims to enable our team to safeguard children and vulnerable adults from physical, sexual and emotional harm while on our premises on an ongoing basis. The practice takes all reasonable steps to ensure that, through relevant procedures and training, children, young people and adults using our services receive safe, well-led, high quality care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Actions** | **Completed** | **Audit and Review Date** | **Signature** | **Date** |
| Appoint a Child Lead and agree job description.  Name: Dr James Hamilton-Smith | Yes | Yes – review March 2019 |  |  |
| Appoint a Vulnerable Adult Protection Lead and agree job description.  Name: Dr James Hamilton-Smith | Yes | Yes – review March 2019 |  |  |
| Check policies reflect the arrangements at the practice:  *Patient Complaints Policy*  *Review Raising Concerns (Whistleblowing)* | Yes | Yes – review September 2019 |  |  |
| Ensure staff have access to: *Safeguarding Procedures Confidentiality Code of Conduct Consent Policy*  *Complaints Policy Raising Concerns Policy* | Yes | Yes – review September 2019 |  |  |
| Create a list of Important Safeguarding Contacts. | Yes | Review details:  September 2019 |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Actions** | **Completed** | **Audit and Review Date** | **Signature** | **Date** |
| Make Record-Keeping Procedures available for:  *Facial Injury recording Disclosure of abuse by patients Concerns of neglect*  *Concerns about bullying Concerns about FGM*  *Other safeguarding concerns* | Yes | Review March 2019 |  |  |
| Obtain the details of the Local Safeguarding Children Board (LSCB) and Local Authority Designated Officer (LADO).  Complete these details and other necessary information on the Important Safeguarding Contacts. | Yes | Review September 2018 |  |  |
| Check that all confidential records are kept in secure locked cabinets. | Yes |  |  |  |
| Add children and vulnerable adult protection training for new staff as part of their induction. | Yes |  |  |  |
| Review recruitment procedures to take account of the need to safeguard children/vulnerable adults.  *DBS Checks References* | Yes | Review date March 2019 |  |  |
| Provide team training to Safeguarding Level 2 | Yes | Review 12/2019 |  |  |

# Appendix 2

## Child Safeguarding Lead Job Description Aim

To ensure that effective measures are taken in the case that a member of the team has concerns for the welfare of a child. Appointing an individual staff member to lead on vulnerable adult safeguarding is intended to be an effective way of ensuring that this issue is not overlooked.

## Attributes of Post Holder Essentials:

» GMC Registered;

» Is a good listener and has respect for confidential information;

» Is able to handle difficult or distressing issues sensitively;

» Thinks before taking action.

## Desirable:

» Good communication skills;

» Able to prepare reports and audits.

Reporting to: The Practice Manager.

Staff reporting to Lead: All practice staff, working in collaboration with all other leads as appropriate.

## The child safeguarding lead could be:

» A GP or any other suitably trained member of the practice staff. The role of the child safeguarding lead includes the following duties:

» Keeping an up-to-date list of local contacts for child vulnerable adult safeguarding advice and referral.

» Making this information readily available to staff.

» Ensuring that practice procedures are available and up-to-date.

» Auditing practice policy.

» Keeping details of local sources of confidential emotional support for staff (this might be needed by staff who are involved in distressing safeguarding incidents, or who have been abused themselves or observed abuse in their families).

» Collating information about local contacts to support these activities.

## Responsibilities of the team

The team is responsible for following procedures laid down in practice policy and for ensuring that they have the skills and knowledge required to safeguard children in the course of their work in the practice.

All staff are responsible for incident reporting and alerting the Child Safeguarding Lead when they have cause for concern.

# Appendix 3

## Safeguarding Vulnerable Adults Lead Job Description Aim

To ensure that effective measures are taken in the case that a member of the team has concerns for the welfare of vulnerable adults to enable them to lead a life free of abuse. Appointing an individual staff member to lead on safeguarding is intended to be an effective way of ensuring that this issue is not overlooked.

## Attributes of Post Holder Essentials:

» GMC Registered;

» Is a good listener and has respect for confidential information;

» Is able to handle difficult or distressing issues sensitively;

» Thinks before taking action.

## Desirable:

» Good communication skills;

» Able to prepare reports and audits.

Reporting to: The Practice Manager.

Staff reporting to Lead: All practice staff, working in collaboration with all other leads as appropriate.

## The Vulnerable Adult Safeguarding Lead could be:

» A GP or any other suitably trained member of the practice staff.

The role includes the following duties:

» Monitoring in house mental capacity assessments.

» Ensuring the team are aware of practice policies for Restraint of Patients, Consent, Confidentiality and Raising Concerns.

» Ensuring that practice procedures are available and up-to-date.

» Auditing practice policy.

» Keeping details of local sources of confidential emotional support for staff (this might be needed by staff who are involved in distressing safeguarding incidents, or who have been abused themselves or observed abuse in their families).

» Collating information about local contacts to support these activities.

## Responsibilities of the team

The team is responsible for following procedures laid down in practice policy and for ensuring that they have the skills and knowledge required to safeguard vulnerable adults in the course of their work in the practice.

All staff are responsible for incident reporting and alerting the Vulnerable Adult Safeguarding Lead when they have cause for concern.

## Appendix 4

**Mental Capacity Assessment**

|  |  |  |
| --- | --- | --- |
| Patient ID:  Name:  Date of Birth: | Why is this assessment considered necessary: | |
| Treatment this assessment is relates to: | If a previous assessment has been made what were the findings? | |
| **Part 1: Is there an impairment or disturbance in the persons brain functions?** | | |
| **Yes**   1. This is permanent condition. 2. This is a temporary condition. 3. This is an irregular condition.   Details: | **No**  Please go to final decision | |
| **Stage 2 Evidence of Capacity** | | |
| Capacity is presumed if the patient can: | Yes/No | Details |
| A. Retain information related to the treatment decision: |  |  |
| B. Retain information about the treatment decision: |  |  |
| C. Use information provided to reach their decision: |  |  |
| D. Communicate the treatment decision: |  |  |
| **If the answer in ‘NO’ to any of the questions above the patient lacks capacity in relation to this decision. If the answer is ‘Yes’ to all questions go to the final decision.** | | |
| Detail all practical steps taken to enable the patient to make a valid decision: | | |

|  |  |  |
| --- | --- | --- |
| **Can the decision be delayed in case the person regains capacity in the future?** | | |
| **Yes**  Go to final decision. | **No**  It is unlikely this person will regain capacity because: | **No**  It is not possible to delay treatment because: |
| **Advanced Decisions to Refuse Treatment made with capacity at an earlier date** | | |
| Was an advanced decision to refuse treatment communicated? | Yes/No | If ‘No’ go to final decision |
| If ‘ Yes’ how was the decision communicated? | Verbally/ In writing | |
| If made verbally to whom and in what circumstances? |  | |
| Date of advanced decision: |  | |
| Is the decision still valid and acceptable? | Yes/No | |
| If ‘No’ give details: |  | |
| **Interested Others** | | |
| Court of Protection Deputy | Name and contact details: | Details of involvement: |
| Lasting Power of Attorney (Financial) | Name and contact details: | Details of involvement: |
| LPA Health and Welfare | Name and contact details: | Details of involvement: |
| Independent Mental Capacity Advocate | Name and contact details: | Details of involvement: |
| Other | Name and contact details: | Details of involvement: |

|  |  |
| --- | --- |
| **Best Interests Decision** | |
| **Details** | |
| Who was consulted about the decision: | Family/carers/ healthcare team/others |
| IMCA Involved: Yes/No |  |
| Views of interested others: |  |
| What would the patient of wanted? |  |
| Views of the team involved: |  |
| Are there any conflicts of interest in respect of this decision? |  |
| **Final Decision** | |
| **Details** | |
| Details of treatment decision: |  |
| Was arbitration required? If yes give details. |  |
| A decision has been made in the patient’s best interests.  This decision has been based on the 5 key principles of the Mental Capacity Act 2005.  This decision was based on the reasonable belief that the patient lacks the capacity to make their own decision. | |
| Name and address of decision maker: | Contact details:  Telephone:  Email: |
| Role of decisions maker: | Date of decision: |
| Signature: | |

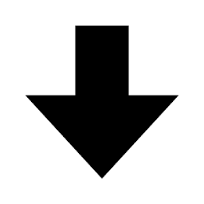
**Appendix 5**

**Local Contact Arrangements**

|  |  |  |
| --- | --- | --- |
| **Contact** | **Telephone/Website** | **Contact Person (if known)** |
| Practice Safeguarding Lead | 0208 5971840 | Dr James Hamilton-Smith |
| Police Switchboard | 999 or 111 |  |
| Social Care Services | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms |
| Children's Services | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms |
| Out of hours emergency team | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms |
| NSPCC | National Helpline: 0808 800500 |  |
| Local Safeguarding Board | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms |
| Police - for FGM Concerns | 0800 028 3550 |  |
| Local Authority Designated Officer  *For allegations against staff* | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms | Revert to 2018 Safeguarding Contact Sheets  (Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms |

**Safeguarding Children and Vulnerable Adults - Guidance for Staff**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| You have a concern or suspicion of abuse happening |  | You have been told abuse is happening |  | You have witnessed an incident of abuse |

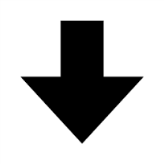


**IN AN EMERGENCY DIAL 999**

If not an emergency contact your Safeguarding lead as soon as possible.

**DO NOT LEAVE IT MORE THAN TWO HOURS FROM FIRST HAVING A CONCERN.**

The lead will contact the Social Services Safeguarding Link Workers for advice.

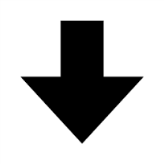


The lead will contact Child Protection & Safeguarding: Revert to 2018 Safeguarding Contact Sheets

(Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms - available 24/7

Safeguarding Vulnerable Adults: Revert to 2018 Safeguarding Contact Sheets

(Barking & Dagenham, Havering and Redbridge) – Located in reception and all clinical rooms – available 24/7



Write up what has been witness and what actions have been taken

**KEEP YOUR NOTES.**

Be available for ongoing liaison and follow-up work as needed - ensure you seek support and guidance from the Practice Manager.

**Appendix 6 Recording of Events**

|  |  |
| --- | --- |
| **Date of incident:** |  |
| **Name(s) of Health Professional(s) involved:** |  |
| **The nature of the injury, or abuse:** |  |
| **Facts to support the possibility that the injuries are suspicious:** |  |
| **Clinical Evidence, Photos etc:** |  |
| **Practices immediate response:** |  |
| **Risk Assessment Outcome:** | **S M A R T** |
| **Outside bodies informed:** |  |

**Appendix 7**

**Definitions of Abuse** - *Ref Safeguarding*

Any of the listed types of abuse may be the result of deliberate intent, negligence, or ignorance. Forms of abuse:

» Physical;

» Psychological;

» Emotional;

» Financial;

» Sexual maltreatment;

» Female Genital Mutilation (FGM);

» Discriminatory;

» Domestic and Violence;

» Professional;

» Institutional;

» Significant harm;

» Neglect of a vulnerable adult by another person.

The abuse may be a single act or repeated over a period of time. It may also take one or more forms. Lack of appropriate action can also be a form of abuse.

## Categories of Abuse

**Physical Abuse (including inappropriate restraint or use of medication)**

This may involve hitting, shaking, throwing, poisoning, burning, or scalding, drowning, suffocating or otherwise causing physical harm e.g. Female Genital Mutilation (FGM). It may be caused by a parent or carer fabricating the symptoms of, or deliberately causing, illness in the victim. Orofacial trauma occurs in at least 50% of children diagnosed (BDA Safeguarding patients) with physical abuse – and a victim with one injury may have further injuries that are not visible.

## Sexual Abuse

This involves forcing or enticing the victim to take part in sexual activities, whether or not the victim is aware of what is happening. The activities may involve physical contact, including penetrative (for example rape, buggery) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

## Psychological Abuse (also known as Emotional abuse and Mental abuse.)

This is a form of mistreatment in which there is intent to cause mental or emotional pain or injury. This is usually persistent and can cause adverse effects to emotional development of its victims. Methods used include verbal

aggression, statements intended to humiliate or infantilise, insults, threats of abandonment or institutionalisation. The results of this abuse results in stress, social withdrawal, long-term or recalcitrant depression and anxiety. It may be noticeable when a patient’s chaperone shows inappropriate expectations being imposed on the patient, interactions beyond the patient’s developmental capacity; overprotection and limitation of exploration and learning; preventing the patient participating in normal social interactions; seeing or hearing the ill-treatment or another; causing the victim to feel frequently frightened or in danger; exploitation and corruption of the victim.

## Financial or Material Abuse

Financial or material abuse involves the use of a vulnerable adult’s property, assets or income without their informed consent or making financial transactions that they do not understand to the advantage of another person.

Some examples are theft, fraud, exploitation, and pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

## Neglect and Acts of Omission

Neglect is behaviour that results in the basic needs not being met. Example are, ignoring medical or physical care needs; person’s physical condition/appearance is poor e.g., ulcers, pressure ulcers, soiled or wet clothing; failure to provide access to appropriate health, social care or educational services; withholding of the necessities of life, such as medication, adequate nutrition and heating; undermining personal beliefs.

## Discriminatory Abuse

Discriminatory abuse is behaviour that makes or sees a distinction between people as a basis for prejudice or unfair treatment. This includes racism; sexism; religious and ageism; based on a person’s disability; slurs or similar treatment.

## Domestic Abuse and Violence

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional between adults, aged 18 and over, who are or have been intimate partners or are family members regardless of gender and sexuality. (Family members are defined as Mother, Father, Son, Daughter, Brother, Sister, Grandparents, whether directly related, in-laws or step-family). Source ACPO 2004.

## Professional Abuse

This is the misuse of power and abuse of trust by professionals, the failure of professionals to act on suspected abuse/crimes, poor care practice or neglect in services, resource shortfalls or service pressures that lead to service failure and culpability as a result of poor management systems/structures.

## Institutional Abuse

Institutional abuse involves the collective failure of an organisation to provide an appropriate and professional service to vulnerable people. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. It includes a failure to ensure the necessary safeguards are in place to protect vulnerable adults and maintain good standards of care in accordance with individual needs, including training of staff, supervision and management, record keeping, unable or unwilling to implement professional or clinical guidelines and liaising with other providers of care.

Abusive behaviour may be part of the accepted custom and culture within an organisation or an individual member of staff, or particular group of staff may carry it out. The key risk factors for institutional abuse are:

» It is widespread within the setting;

» It is repeated;

» It is generally accepted, it is not seen as being poor practice;

» It is sanctioned, it is encouraged or condoned by line managers;

» It takes place in a setting where there is poor monitoring by senior management;

» There are environmental factors (e.g. unsuitable buildings, lack of equipment, many temporary staff) that adversely affect the quality of care;

» It is systematic e.g. factors such as a lack of training, poor operational procedures, poor supervision and management all encourages the development of institutionally abusive practice.

## Significant Harm

This can be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.

**Key Lines of Enquiry Table**

|  |  |
| --- | --- |
| **Key Line of Enquiry** | **Supporting** |
| HE6 - Is consent to care and treatment always sought in line with legislation and guidance? |  |
| HR4 - How are peoples concerns and complaints listened and responded to and used to improve the quality of care? |  |
| HS1 - How do systems, processes and practices keep people safe and safeguarded from abuse? |  |
| HS3 - Do staff have all the information they need to deliver safe care and treatment to people |  |
| HS5 - What is the track record on safety? |  |
| HS6 - Are lessons learned and improvements made when things go wrong? |  |
| HW5 - Are there clear and effective processes for managing risks, issues and performance? |  |