

# Manchester Safeguarding Adults Board

## Guidance on Thresholds for Safeguarding Adults Referrals

This document has been written to assist practitioners to determine whether or not adult protection procedures should be triggered.

Determining whether or not abuse of a vulnerable adult has taken place is not always a straightforward matter, particularly when there are issues of neglect. A judgement may be required about whether an act or an act of omission has caused significant harm. In some cases it is the repetition of minor actions or omissions that collectively will amount to abuse.

The expectation in the Manchester multi agency Safeguarding Adults policy of anyone suspecting abuse is **if in doubt report**.

The multi agency arrangements for responding to possible abuse exist to establish whether or not abuse has occurred. It is very important that these arrangements (Strategy discussion and Strategy meeting) are triggered if there is a possibility of abuse. Some very serious abuse only comes to light because people raising the alert have drawn the attention of social services or police to what may appear to be relatively minor concerns.

It is important to note that the abuse does not need to be deliberate. Some neglect is not deliberate. It is not the intent which needs to be considered but the harm which has resulted from the act or omission and which should trigger the multi agency Safeguarding procedures.

The Manchester Multi agency Safeguarding Adults Procedures place a duty of care on all health and social care staff, statutory and independent sectors, to report allegations, concerns and suspicions of abuse. The Safeguarding Procedures are designed to identify whether or not there is abuse – workers do not need to make such judgements on their own. Safeguarding Adults Co-ordinators can be contacted and consulted about possible referrals.

It is in the areas of neglect and use of constraint, force and deception where the greatest uncertainty often arises with respect to possible abuse. The following examples are provided, relating to care settings such as hospitals and care homes, to help workers to determine if the Safeguarding procedures should or should not be triggered.

The significance and importance of abuse is such that abuse investigations must take precedence over investigations which might otherwise be conducted into complaints or untoward incidents.

Safeguarding Adults procedures take account of disciplinary procedures, duties of employers and the rights of alleged perpetrators. It is expected that an employer will make a judgement about the need to suspend or re deploy an alleged abuser pending investigation. Evidence gathered for a safeguarding adults investigation will be available after the conclusion of the

investigation for any disciplinary investigation which may subsequently be required. Any disciplinary investigation should not commence until after the conclusion of the safeguarding adults investigation unless this has been agreed at a strategy meeting.

The following Guidance may be used to assist in decision making as to whether or not safeguarding adults procedures should be triggered:

	<b>Poor practice which requires actions by a provider agency e.g. homes, ward or domiciliary care manager</b>	<b>Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures</b>
1	Patient/service user does not receive necessary help to have a drink/meal. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home, incident dealt with under staff disciplinary procedures; would not be referred under safeguarding adults procedures	Patient/service user does not receive necessary help to have drink/meal and this is a recurring event, or is happening to more than one vulnerable adult. This constitutes neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation
2	Patient/service user does not receive necessary help to get to toilet to maintain continence or have appropriate assistance such as changed incontinence pads If this happens once and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home, dealt with under staff disciplinary procedures; would not be referred under safeguarding adults procedures	Patient/service user does not receive necessary help to get to toilet to maintain continence and this is a recurring event, or is happening to more than one vulnerable adult – neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation
3	Patient/service user has not been formally assessed with respect to pressure area management but no discernible harm has arisen. This may need to be dealt with under disciplinary procedures	Patient/service user is frail and has been admitted without formal assessment with respect to pressure area management. Care provided with no reference to specialist advice re diet, care or equipment. Pressure damage occurs. Neglectful practice, breach of regulations and contract, possible institutional abuse. Safeguarding procedures should be instigated.
4	Patient/service user does not receive medication as prescribed on one occasion but no harm occurs Internal investigation should be undertaken, possible disciplinary action depending on severity of situation including type of medication	Patients/service users do not receive medication as a recurring event, or it is happening to more than one vulnerable adult. Neglectful practice, regulatory breach, breach of professional code of conduct if nursing care provided. Dependant on degree of harm, possible criminal offence. Safeguarding procedures should be implemented.
5	Appropriate moving and handling procedures not followed but patient/service user does not experience harm Provider acknowledges departure from procedures and inappropriate practice and deals with this appropriately under disciplinary procedures, to the	One or more service users experience harm through failure to follow correct moving and handling procedures, or common flouting of moving & handling procedures make this likely to happen. Neglectful practice – safeguarding procedures should be instigated

	<b>Poor practice which requires actions by a provider agency e.g. homes, ward or domiciliary care manager</b>	<b>Possible abuse which requires reporting as such, and the instigation of Safeguarding procedures</b>
	satisfaction of service user	
6	<p>Patient/service user is spoken to in a rude, insulting, belittling or other inappropriate way by a member of staff. They are not distressed by the incidence and this is an isolated incident</p> <p>Provider takes appropriate action, to the satisfaction of the service user</p>	<p>Patient/service user is frequently spoken to in a rude, insulting, belittling or other inappropriate way or it is happening to more than one vulnerable adult. Regime in the home doesn't respect dignity of service users and staff frequently use derogatory terms and are abusive to service users.</p> <p>Regulatory breach Refer under safeguarding procedures</p>
7	<p>Service user does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs.</p> <p>Provider deals with this appropriately through internal investigation, to the satisfaction of service user</p>	<p>Service user does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being resulting in harm or potentially serious risk to service user</p> <p>Safeguarding procedures should be instigated</p>