BARNSLEY SAFEGUARDING ADULTS BOARD

# Decision Support Guidance 2024 – 2026

## Do I need to raise a safeguarding adults concern?

**Supporting a proportionate, person-centred response to keeping adults in Barnsley safe.**

SECTION **ONE**

# CONTEXT AND PURPOSE OF THE GUIDANCE

## Context

The Care Act (2014, enacted 2015) states that local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult:

- Has needs for care and support (whether or not the local authorities are meeting any of these needs) **and**
- Is experiencing, or at risk of, abuse and/or neglect **and**
- As a result of those of care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The Care Act is very clear that any response needs to be:

- Person centred – driven by their wishes and feelings (outcomes)
- Proportionate – based on empowerment and prevention and
- Reduce the risk of further abuse/neglect.

This decision support guidance has been developed to support practitioners to assess:

- The risk to the adult(s),
- The impact on the adult(s) and
- The level of response required and whether it is proportionate to use the safeguarding (Section 42) enquiry process.

## Purpose of the guidance

The guidance has been developed to support all workers to make consistent decisions about what should be sent to Adult Social Care as a safeguarding concern.

The guidance is **not** intended to replace professional judgement and if it is being used by care providers and they are not sharing a safeguarding concern they **must** share a low-level concern form, and if appropriate notify CQC (Care Quality Commission), the decision should be approved by managers within your organisation and logged appropriately on the adult's records.

The guidance should promote:

- Consistency of decision making
- Use of alternative processes as a proportionate response to concerns that do not need to be managed as S42 enquires and
- Empower partners & independent providers to use a range of responses, proportionate to the risks.

If a partner or independent organisation decides not to raise a safeguarding concern with the local authority, they must be able to evidence:

- A detailed record of the incident, evidencing the vulnerability of the adult, the impact on the adult, the adult's views (if they can give these), what actions have been taken to address the immediate risks and to prevent further harm?

- A recording system that supports identification of repeat concerns about the same issues and /or adult(s) and not be reliant on memory of managers/ staff and
- That discussions have taken place with the adult or their advocate/family about their views on what responses are required/ available, this should include the option to raise a safeguarding concern with the local authority.

If any doubt exists about the need to raise a safeguarding concern, advice should be sought via the **Customer Access Team**:

Telephone: **01226 773300**

Email: socialservices@barnsley.gov.uk

If you do not have a secure email, please use Egress or ring to share your concern.

Care Homes have a low-level concern form to report falls and medication errors in cases where harm has not taken place. These should be shared with the adult social care for assessments but will not be counted as safeguarding concerns.

Repeat low level concerns relating to the same adult or issues **MUST** be shared in a timely manner with the Local Authority. Failure to do so may result in an organisational safeguarding enquiry. Link to policy

https://www.barnsley.gov.uk/media/24324/organisational-abuse-policy.pdf

# SECTION TWO - GUIDANCE TOOL

This tool is designed to support you in considering the following:

- The ability of the adult to manage the risks and prevent further harm on their own or with limited support.
- The seriousness of the harm and the risks to other adults who may be less able to reduce the risks/prevent further harm.
- The risk of the harm reoccurring to the individual or other adults
- The impact of repeated low-level concerns that have failed to be addressed via contract management processes.

The guidance does not replace professional judgement and decision making and does not require the local authority to lead on any subsequent enquiries if a more appropriate partner or independent provider is better placed to do so.

| **Type of harm and impact on adults** | **Limited impact on adult / no or limited risks to other adults MAY not need to be referred as S42 concerns** | **Serious risk to adults or significant harm occurred. Involvement of medical, police or other emergency services must be shared as S42 concerns** |
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| | Cases that have the factors listed below may not need to be shared with the local authority as safeguarding concerns. If they are shared it is likely they will be screened out and dealt with via other processes such as case management etc. If the concerns are not shared as safeguarding concerns, they must be shared with CQC (Care Quality Commission) (if outlined in CQC (Care Quality Commission) statutory notifications guidance) and contract management team on a low-level concern form and **recorded to identify any trends/patterns.** Safeguarding concern form. https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/for-professionals-and-volunteers/ (referral forms) | Safeguarding concerns with the factors listed below must be shared with the local authority as soon as possible, if necessary, using out of hours contacts, police or other emergency services. An immediate protection plan should always be considered and/or implemented. |
| **Physical** | ➢ Friction mark (but no break in the skin) caused by family carer.<br>➢ Friction mark but no break in the skin (as above) caused by staff using hoist or other moving and handling equipment correctly and who have been appropriately trained.<br>➢ Isolated incident between two adults who lack capacity whose care plans do not indicate they need one to one or | ➢ Accumulation of minor incidents, especially if they involve the same member of staff.<br>➢ Recurring missed or incorrect medications even if they did not result in harm to adult.<br>➢ Use of covert medication without evidence of appropriate agreement of family, medical professionals etc. |

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| **Physical** | close supervision.<br>➢ Inexplicable marks – but skin intact tears, injuries needing medical attention found on one occasion.<br>➢ Injuries resulting from falls that have occurred despite following agreed fall management plans.<br>➢ Falls that do not result in any injuries and the care plan has been followed should result in a low-level concern form in care homes See appendix 4.<br>➢ Injuries resulting from restraint, required to keep the person safe, are included in care plans and have been regularly reviewed.<br>➢ One-off medication error for one adult, no harm occurred, and adult does not want any action taking. (see appendix 2) | ➢ Injuries resulting from denying the adult access to food/drink, mobility aids or lack of timely response by staff<br>➢ Unexplained injures that require medical intervention or hospital admissions.<br>➢ Physical assault by a worker or member of family.<br>➢ Falls that result in injury, were the care plans are not up to date or not followed.<br>➢ Injuries resulting from adult-on-adult contacts when the adults care plan indicates the need for close supervision.<br>➢ Restraint injuries – if not included in care plans and evidence of regular review<br>➢ Deliberate maladministration of medication by family or staff.<br>➢ Witnessed assaults by a worker or member of family.<br>➢ Pressure ulcers scoring 15 or more – see guidance - Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk) |
| **Sexual** (including sexual exploitation) | ➢ Isolated incident that did not cause distress or injury between two adults who both lack capacity to consent to sexual contact. The risk was not known or recorded in their care plans.<br>➢ Verbally inappropriate sexual banter between adults with capacity who are willing participants in this conversation.<br>➢ Inappropriate use of social media etc., by adults who have capacity but may lack appropriate boundaries.<br>➢ Sexual contact between two workers observed by adults without the workers' knowledge. | ➢ Sexual contact by a member of staff with an adult in their care.<br>➢ Sexual voyeurism by staff members or volunteers.<br>➢ Inappropriate use of pornographic material in the workplace.<br>➢ Sexual relationship between a worker/ volunteer and a person who receives care/ support from the worker/ volunteer.<br>➢ Facilitating sexual contact with adults not |

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| Sexual | ➢ Purchase of inappropriate clothing, by family members, which suggest they can make choices to engage with sexual activity, when they lack capacity to make this choice and the choice of clothes.<br>➢ Use of pornographic materials by an adult with capacity for their own benefit or if recorded as a best interest decision in their care plan | involved in their care, when the adult cannot consent to this, especially if this involves payment to the worker/ volunteer arranging this.<br>➢ Indecent exposure by the worker/ volunteer or encouraging indecent exposure or touching by the adult for the benefit of the worker.<br>➢ Grooming activity (gifts, meals etc) in return for sexual contacts.<br>➢ Female genital mutilation.<br>➢ Use of medication or other substances to remove the ability of the adult to consent or to sexual contact.<br>➢ Coercion or threat to obtain the agreement of the adult to sexual contact. |
| **Psychological** | ➢ Stressed family carer speaks inappropriately to an adult but is immediately remorseful.<br>➢ Worker is rude to an adult following an attack by the adult on them.<br>➢ Purchase of clothing by family or workers that is not age appropriate and do not reflect the adult's ability to make decisions about clothing/image.<br>➢ Family or workers limit information available to the adult to 'protect them' which limits or disempowers them.<br>➢ Workers have inappropriate conversations about adults while providing care to them. The adult(s) has limited awareness or memory of this. | ➢ The adult is frightened or distressed by a verbal outburst.<br>➢ The language and behaviour used by carers/workers does not improve despite training and/or other interventions.<br>➢ Intimidation, particularly when it results in power to the worker/family member.<br>➢ Coercing an adult to amend their Will/gift items/ give money etc. by use of threats to limit contact with family/ access to activities etc.<br>➢ Images and/or information about adults unable to consent to this is shared on social media or other platforms by workers or volunteers.<br>➢ Any threats of harm/abandonment by a person in a position of power – this includes family members. |

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| **Financial or material** | ➢ Money transactions not recorded appropriately or in line with policies, no money missing.<br>➢ Adults with capacity are not routinely involved in the use of their money.<br>➢ Care fees not paid on behalf of the adult but are paid when the debt is highlighted Adult is persuaded to spend on items that have no benefit to them, that are used primarily or exclusively for the benefit of family members.<br>➢ Workers accept gifts of money or goods from an adult, who has capacity, on an occasional basis – birthdays, Christmas etc in line with the organisation's policies. | ➢ Adult has no access to their money and has no food etc.<br>➢ Adult's possessions are sold without their knowledge or consent for the benefit of others.<br>➢ Care fees not paid by people responsible for their finances despite many requests.<br>➢ Theft by family or workers of money or goods.<br>➢ Use of the adult's name/address to purchase goods online or via catalogue by another person.<br>➢ Adult's details used to obtain loans, credit etc. without their knowledge or consent.<br>➢ Fraudulent claims for benefits etc. without the knowledge/consent of the adult.<br>➢ Workers persuade adult to purchase items that are primarily or exclusively for the benefit of the worker(s). |
| **Neglect and acts of omission** | ➢ Adult is not supported to eat/drink on one occasion and no harm occurs.<br>➢ Adult does not get access to medical care (optician etc) in a timely manner, but no harm or distress occurs.<br>➢ Adult' access to required independence aids (walkers etc) as family are worried, they will fall and injure themselves, but no harm occurs.<br>➢ Adult is not supported to bathe/change clothes are frequently as they would like but is not distressed by this (consider complaint).<br>➢ Adults do not get access to outings due to staff shortages but are otherwise well cared for (unless included as a DoLS (Deprivation of Liberty Safeguards) condition).<br>➢ A home care visit is missed but no harm occurs, and the adult's needs are met by them or their family. | ➢ Adult is frequently left without support (paid or unpaid), and they are unable to meet their own basic needs.<br>➢ Adult is discharged from hospital without appropriate plans in place and harm and / or distress occurs, or the adult is readmitted within 48 hours.<br>➢ Care, in any setting, is not adequate to prevent avoidable tissue viability issues, dehydration, malnutrition, etc. see guidance - Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK (www.gov.uk) Appendix 3<br>➢ Failure to access medical services – GP, ambulance etc. results in harm or distress to the adult. |

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| | ➢ Adult's dietary choices are not met but this does not result in harm or distress.<br>➢ Adult's choices are limited by overprotective family or staff.<br>➢ Falls resulting from not following care plans that do not result in harm | ➢ Family or staff fail to intervene to protect adult who lacks capacity to make the necessary choices, and this results in harm or distress.<br>➢ A care provider fails to report missed visits on a regular basis and harm or distress results to one or more adults.<br>➢ A care provider who has an action plan with its commissioner(s) fails to report issues that are linked to the agreed action plan (e.g. missed medication or medication errors).<br>➢ Falls resulting in injuries caused by lack of adherence to the adult's care plan |
| **Organisational abuse** | ➢ Lack of activities that would support adults to fully engage within the care setting.<br>➢ Adults' views not considered in making decisions about the way the service is run.<br>➢ Staff training is not up to date but no issues with practice and care.<br>➢ Care plans are poor and are not person- centred but do not result in harm due to staff knowledge of adults using the service.<br>➢ The adults are not supported to take risks but are not harmed by the lack of stimulus.<br>➢ Staffing is not at the required levels, but core services are being delivered and plans are in place to address staffing issues. | ➢ Staffing levels and appropriate skill mix cannot deliver safe care and person-centred responses.<br>➢ Food is not edible or is insufficient to meet the needs of adults.<br>➢ Staff have not received mandatory training or training necessary to meet the needs of adults receiving care and support from the organisation and this has caused or put at risk of harm adults in receipt of care.<br>➢ Staff have not received specialist training to meet adults needs (e.g. catheter care etc.) but adults who require this specialist care are using the service.<br>➢ Lack of management or management vacancies results in poorly run service placing adults at risk or experience of harm.<br>➢ Over-medication is used to manage adults to compensate for staff shortages.<br>➢ The care provider runs on high use of agency staff who are not given appropriate inductions and multiple errors occur in providing care to adults.<br>➢ High levels of restraint are used, very little of which is written into care plans.<br>➢ Staff control individual adults' finances, and the adults have no knowledge of their finances. |

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| **Discriminatory abuse** | ➢ Family or carer tease an adult based on their differences. The adult is not distressed by this, but it is outside accepted work practices.<br>➢ The care plan does not fully address an adult's individuality but is rectified when this is highlighted by the adult/their family or the commissioner.<br>➢ Inappropriate conversations between paid members of staff not directly aimed at an adult in their care that is addressed by the manager when identified to them.<br>➢ Lack of staff prevent adults who do not follow the 'norms' of the services following their beliefs on a temporary basis. | ➢ Service supports discriminatory language or behaviour by failing to train staff or address concerns when raised by adults or their families.<br>➢ Failure to meet specific care needs agreed as part of care plan linked to diversity.<br>➢ Humiliation by staff or by other adults (supported/permitted by staff).<br>➢ Hate crimes – assault, murder etc.<br>➢ Refusal to obtain medical help despite adult's requests as the worker does not believe them due to their beliefs about the person.<br>➢ Refusal to allow adults their civil rights e.g. voting, making a complaint etc.<br>➢ Any action or behaviour that distresses the adult or their family based on discriminatory beliefs – race, sexuality, beliefs etc. |
| **Type of harm and impact on adults** | **Limited impact on adult / no or limited risks to other adults MAY not need to be referred as S42 concerns** | **Serious risk to adults or significant harm occurred. Involvement of medical, police or other emergency services must be shared as S42 concerns** |
| **Modern Slavery** | ➢ **All** concerns must be reported immediately to the police and adult social care | ➢ Being forced to work for little or no money, often for very long hours.<br>➢ Denied or limited access to medical or other services.<br>➢ Forced marriage.<br>➢ Limited access to food and shelter Poor quality food and shelter Removal of ID or passport.<br>➢ Sold for sex or sent out to work as a prostitute.<br>➢ Beaten or threatened with violence if money is not handed over.<br>➢ Organs sold for transplants.<br>➢ Poor/overcrowded living conditions.<br>➢ Threats that children will be removed from country. |
| **Domestic abuse** | ➢ All incidents of domestic abuse should be screened using the DASH risk tool and, if necessary, referred to MARAC if high-risk | ➢ Stalking.<br>➢ Threats or attempts to kill.<br>➢ Rape or serious sexual assault. |

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| | identified. If low or medium risk and the adult is an adult at risk, a referral to adult social care should be made unless the adult has capacity and is making a **free** from coercion choice to remain in the relationship. | ➢ Refusing access to services/support without consent of adult.<br>➢ Refusal to allow adult to speak on their own with services/workers/family/ friends.<br>➢ Evidence of injuries that do not match the explanation provided.<br>➢ No access or control over finances. |
| **Self-neglect** | ➢ If the adult has capacity and is making unwise decisions with regards self-neglect advice should be given, the situation monitored and fully recorded, including evidence of any assessments of the adult capacity to make choices about the areas of concern. | ➢ The risks to the adult pose serious risks to their health. Self-neglect policy link: Barnsley - SN & Hoarding Summary<br>➢ The risks extend to neighbours or family members – fire risk etc.<br>➢ The adult's life is in danger due to lack of engagement.<br>➢ It is not possible to reliably assess their capacity.<br>➢ The adult cannot demonstrate executive capacity.<br>➢ The risks to the reputation of organisations involved in the care of the adult are high. |

| | **Factors** | **Guidance Questions** |
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| **Vulnerability of the adult at risk (less or more able to protect themselves)** | ➢ More or less able to protect themselves?<br>➢ Previous experience of abusive relationships/situations?<br>➢ Evidence of duress or coercive control?<br>➢ Support available to them to address without an S42 enquiry (this may include family, friends, voluntary organisations etc)? | ➢ Does the adult have care and support needs?<br>- If no, exit S42 and signpost to relevant support agencies.<br>- If yes, are the care and support needs being met by any agency?<br>- If yes, can the adult and the agencies involved with them resolve the issues outside of a S42 enquiry? This must be recorded, and the safeguarding manager must be satisfied it meets the adults' stated outcomes.<br>➢ Does the adult have capacity to recognise the abuse/harm?<br>➢ Does the adult have capacity to consent to a S42 enquiry?<br>- If no, a best interest decision should be taken.<br>➢ Is the adult dependent on the alleged source of harm?<br>➢ Can the adult raise future concerns if the situation does not improve? |
| **Alleged source of harm (ASH)** | ➢ Does the ASH have a criminal or other history of abusive acts?<br>➢ What is the nature of the harm/abuse (unintended/ill–informed, opportunistic or targeted and deliberate)?<br>➢ What is the relationship and power balance between ASH and adult at risk? If the ASH is a worker or volunteer a | ➢ Does the ASH have a relevant criminal history?<br>➢ Does the ASH have a history of domestic abuse?<br>➢ Does the ASH have a history of involvement in safeguarding adults or children's cases?<br>➢ Does the ASH have a relevant disciplinary misconduct history?<br>➢ Is the ASH in a position of power in relation to the adult at risk or other adults at risk? |

| | Factors | Guidance Questions |
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| | Person in Position of Trust referral to social care must be raised | |
| **Level of harm / abuse** | ➢ The adult's perception of how serious the harm is, compared with our assessment of the risks must be considered. We may act against the wishes of the adult if other adults are at risk. | ➢ How seriously does the adult view the harm/abuse?<br>➢ How does this compare with our assessment of the harm/abuse and the risk of further harm/abuse?<br>➢ Are other adults at risk of harm and/or abuse by the alleged source of harm?<br>➢ Context of the harm – one-off or part of a longstanding pattern?<br>➢ Is this an escalating situation – number of concerns?<br>➢ Does the harm/abuse meet the threshold for a criminal investigation? |

| | Factor | Factor | Factor | Guidance Questions |
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| **Pattern of harm/abuse** | Isolated incident | Abuse confined to an ongoing relationship of the adult's choosing.<br><br>No coercion or duress?<br><br>The adult has capacity to make this decision. | Repeated abuse in a relationship that the adult is unable to leave or in a situation the adult is unable to control (e.g. care setting) | |
| **Impact on adult** | None or limited impact | Significant impact but no long- lasting effects | Serious impact with permanent or long-term impact | ➢ The views of the adult about the situation must inform the decision-making, even if it is in our view significant.<br>➢ Capacity of the adult to remember the incident should not impact on our S42 decision. Other evidence should be sought if an S42 is in their best interests or required to protect other adults.<br>➢ Serious impact, including death, must be considered in S42 if the cause of death is linked to another person/organisation (an SAR (Safeguarding Adults Review) should be considered).<br>➢ Adults who lack capacity to give a view about the harm and its impact should be supported via a best interest meeting/ decision. |

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| **Risk of repeated abuse or harm to the adult at risk** | Unlikely to recur due to protection plan or absence of alleged source of harm | May recur as the adult will struggle to remove all contact with the alleged source of harm | Likely to recur as the adult has regular contact with the alleged source of harm | ➢ Can the risks be reduced by provision of training, additional support, alternative support, criminal intervention?<br>➢ If the risks cannot be reduced by any of the above and the adult has capacity, seek their views about what actions they would like to take. Ensure that the adult is not under duress or coercion – talk to police about use of domestic violence legislation.<br>➢ If the adult lacks capacity a best interest decision should be taken as soon as possible. |
| **Impact on others** | Nobody else affected | Others indirectly affected | Others directly affected | ➢ Direct impact on other adults – do they have capacity? What are their views?<br>➢ Impact on others in the environment that the adult lives in.<br>➢ Impact on relatives or other adults distressed or affected by the abuse.<br>➢ Impact on other staff members who work in the service. |
| **Risk of repeated harm to other adults** | Other adults not at risk | Adults may be at risk but can be managed via disciplinary or other processes | Adult likely to be at risk and no immediate ways to reduce the risk e.g. personal assistant or neighbour etc. | ➢ Does the risk extend to children as well as adults?<br>- If yes, consider use of child protection procedures.<br>➢ Would an early contact with the DBS assist in reducing the risks?<br>➢ Would action by an employer and/or contract management team assist in reducing the risk?<br>➢ Can the police offer any support in reducing the risks? |
| **Intent of alleged source of harm (ASH)** | Unintended or due to lack of support or information - ASH very remorseful | Opportunistic within family or work situation - may not be an isolated incident | Deliberate, makes attempts to cover actions or discredit adult | ➢ Is this a stress reaction by either a family member or worker?<br>➢ Were violence or threats of violence involved?<br>➢ Was the act a breach of professional conduct or employment responsibilities?<br>➢ Did the alleged source of harm 'gain' because of the act (financially, emotionally etc)?<br>➢ Does the alleged source of harm pose a risk to other adults? |

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| **Criminality of act** | No criminal acts/not illegal but may be in breach of employment contract | Illegal, but may not meet the threshold for a criminal investigation. | Illegal and likely to meet threshold for criminal investigation | ➢ Always seek advice from the police before making the decision about criminal thresholds.<br>➢ If the act is in breach of employment contract/codes of conduct. Best practice is to suspend until advised otherwise by the Police/Human Resources |

## Appendices

1. **Falls protocol**
2. **Medication incidents**
3. **Low level concern form – care homes only**

**Appendix 1 - Falls protocol**

BARNSLEY SAFEGUARDING ADULTS BOARD

# Protocol for Falls and Adult Safeguarding

Document Control

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| Version | V1 draft |
| Date written | April 2024 |
| Name of originator/author | David Yockney |
| Approval date | July 2024 |
| Date issued | TBC |
| Review date | July 2027 |
| Target audience | Care workers |

# Introduction

A fall should be seen as an event that needs **questioning and investigating and recording** to prevent future occurrence.

Many falls are preventable, but not all, particularly within the care home setting where some of the most frail and dependent of our population reside. However, staff should take a preventative approach to falls, in the delivery of high-quality care.

Prevention of falls should be our aim, and this is underpinned by appropriate risk assessment, individualised care planning, good team communication and following appropriate post-fall procedures including reporting. (Link to the falls pathway)

This protocol is to support the decision whether to report a fall as a safeguarding adult concern to Barnsley Adult Social Care.

A safeguarding adult concern must be reported to Barnsley Adult Social Care when a resident or service user falls, and the fall was probably preventable and abuse and or neglect by a worker feature in circumstances surrounding the fall.

You must ensure there is clear documentation in the care records to explain when the decision is made not to report a fall as a safeguarding concern.

This protocol only covers the decision making in relation to adult safeguarding concerns following a fall and you must still follow your organisation's process around informing the Care Quality Commission or requirements from Barnsley Adult Joint Commissioning (AJC).

If you need support or advice about whether to make a safeguarding referral, contact Adult Social Care on 01226 773300 (Barnsley Safeguarding Referral Form)

All care providers who are subject to organisational abuse procedures and/ or an embargo **must** complete and submit a Low-Level concern form following all falls as a minimum and follow this protocol to guide whether to report a safeguarding concern. All other providers can use this guidance and professional judgement to determine if either a safeguarding or a low-level referral is appropriate.

# Report a safeguarding concern in the following circumstances:

- When there is a concern about possible abuse or neglect by another person
- When a person is identified as being at risk of falls and there is concern that an appropriate risk assessment and care plan is not in place or is not being followed i.e., there is evidence of neglect.
- Any fall where there is suspected abuse or neglect by a staff member or other person or a failure to follow relevant care plans, policies, or procedures.
- Significant or very significant harm has occurred because of the fall such as a fracture.
- When a person has an injury, other than a very minor injury, which is unexplained.
- When staff have failed to follow procedures after a fall

- When appropriate measures have not been taken to maximise the safety of the person from an environmental perspective, including avoiding harm from other clients / service users.
- Where a person has fallen more than once during a 6-month period requiring attendance at hospital
- Multiple falls involving the same person where it is not clear that professional advice or support has been sought at the appropriate time.
- Where there have been other similar incidents or areas of concern, for example an increase in the overall number of falls in the care home.

Some falls may be because of self-neglect such as a lack of self-care, lack of care of the adult's environment or a refusal of services. Mental capacity around these decisions will be a key consideration in these cases. For example, a service user has a fall at home due to living in a hoarded property which they have declined to accept support with cleaning and has capacity to decline. In such cases the Barnsley Adult Board Self neglect and Hoarding Policy must be followed.
Barnsley Self-neglect & Hoarding Policy

When considering whether or not a fall is the result of neglect, it is necessary to establish that everything practicable was done to reduce the risk of the person falling. Whilst not an exhaustive list, the following should be considered:

- Has an appropriate and adequately detailed falls risk assessment been undertaken?
- Has there been a reassessment of the adult's risk factors after each fall, and prevention measures updated?
- Is there evidence that adults have been supported to make decisions about how they might reduce their risk of falling?
- Has a Mental Capacity Assessment been undertaken where a lack of mental capacity might compromise the person's ability to understand the risk of falling?
- Are any falls-related restrictions or restraint measures taken for an adult who lacks capacity evidenced in best interest records and in their support plan? Has this resulted in a request for a Deprivation of Liberty Safeguards assessment?
- Is there evidence that referrals have been made to appropriate health care professionals once a risk has been identified?
- Is there a concern around meeting the resident's nutritional and hydration care or the impact of their prescribed medication?
- Are there opportunities for adults to exercise safely, and they are supported to remain as mobile as possible?
- Are staff trained to ensure they are competent in moving and handling of adults in relation to falls prevention?
- Is the appropriate equipment being used correctly and are staff trained in its correct and safe use? e.g., hoists?

- Is the equipment in good repair?
- Are call bells or alerting systems in place, being used, and monitored?
- Are there hazards around the premises that could lead to falls? e.g., uneven or worn flooring or ground, changes in levels, types of floor covering, lack of appropriate safety measures around stairs, poorly lit areas, trailing wires?
- Has falls data (within residential / nursing homes or hospitals) identified patterns, been evaluated, and acted upon? For example, time of falls, mealtimes, environmental factors?

This tool is to aid decision making about falls and safeguarding concerns. These are just a few examples, and this does not replace professional judgement or aim to set a rigid criterion for intervention. It helps you consider the type of abuse and the circumstances in which a safeguarding concern would be reported to the local authority

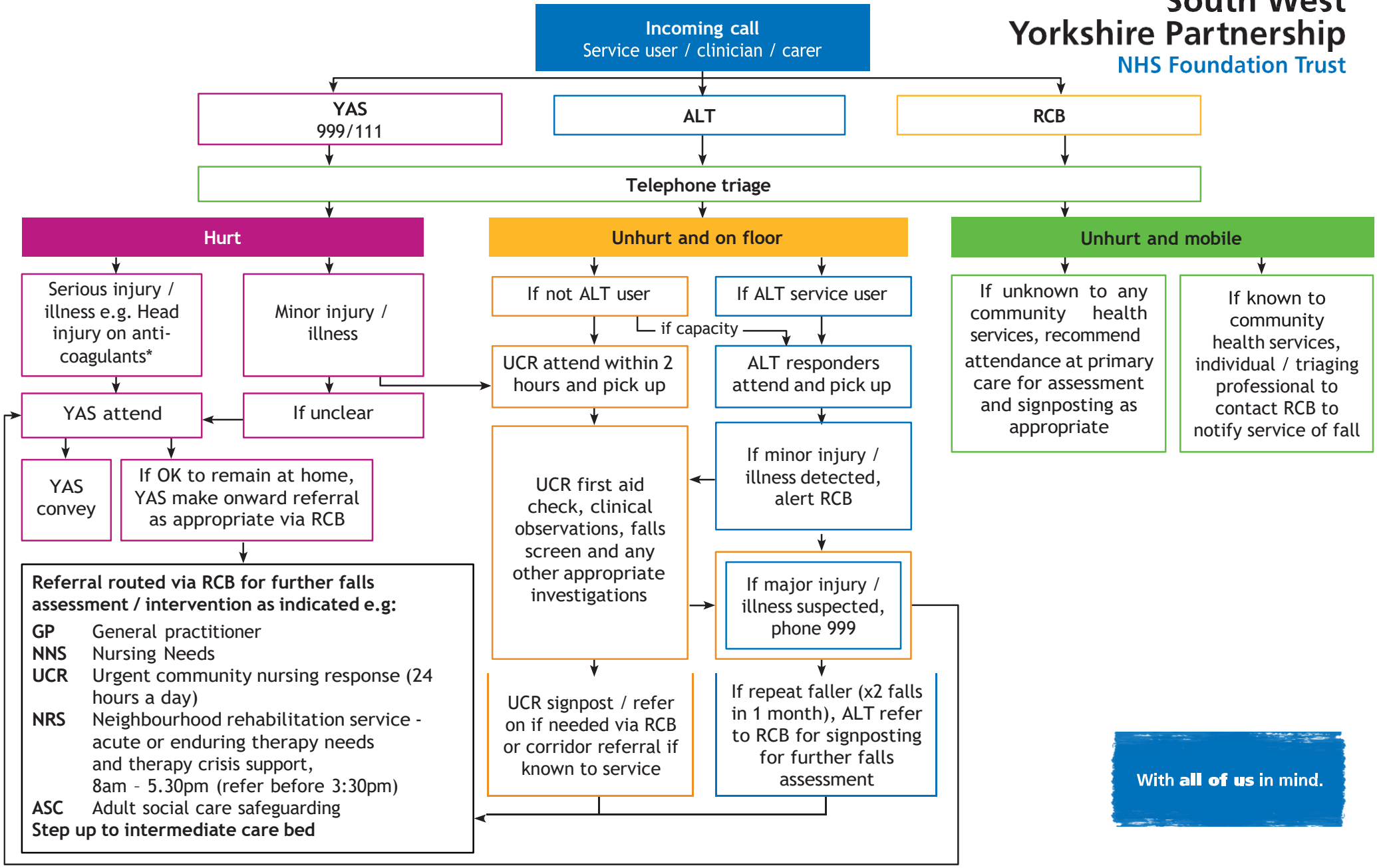
| **Falls** | | | | |
|---|---|---|---|---|
| | An isolated or multiple incidences where no significant harm has occurred, where no abuse or neglect has been identified and where action is being taken to minimise further risk which is demonstrated in the care plan. | An isolated incident requiring attendance at hospital and no other form of abuse or neglect is suspected. | The risk could not have been anticipated or there is a risk assessment in place, the person is able to explain the fall which does not indicate abuse or neglect; and post fall procedure was followed. | **A SAFEGUARDING OR LOW-LEVEL CONCERN IS UNLIKELY TO BE REQUIRED. HOWEVER PROFESSIONAL JUDGEMENT MUST BE APPLIED. CARE PROVIDERS SUBJECT TO EMBARGOS OR IN ORGANSATIONAL ABUSE ENQUIRIES MUST SUMBIT A LOW-LEVEL CONCERN** |
| The adult has experienced harm because of the fall and this harm could have been prevented if appropriate risk assessments/care plans/equipment/staffing was in place. | Any fall where abuse, neglect self-neglect or omission of care is suspected. | The adult has repeated unexplained injuries because of falls. | Where medication has not been given on time resulting in a fall and injury. OR the adult has been overmedicated. | |
| Where members of staff are involved have not received training in falls prevention/management and/or not adhering to the falls policy and protocols following a fall or where supervision levels are insufficient to ensure safety. This could be organisational abuse. | Where environmental hazards, such as poor lighting or clutter, result in fall and injury. | Where bedrails are used but where they are not risk assessed, where the least restrictive option was not considered. | There is no evidence of the care plan being reviewed and updated following a fall or a change of circumstance. | |
| Where the fall has happened in a care home or service where a safeguarding enquiry into organisational abuse is taking place. | Where there have been multiple falls within the same setting within a short period of time (either the same or different service users/residents). | Where an adult has had a fall and declines intervention where services feel this is needed (for example if there is clear evidence of mobility issues | Where appropriate medical intervention or advice was not sought promptly after the fall, despite evidence that this was required. | |

| | | | | |
|---|---|---|---|---|
| | | | | |
| Where the fall was a result of physical abuse (such as pushing, hitting, punching, kicking) and the person has been harmed. | | | | |
| An isolated or multiple incidences where no significant harm has occurred, there is no evidence of abuse or neglect and where a risk assessment and care plan are in place and has been followed. | | | | |

| | | | | |
|---|---|---|---|---|
| An adult has a falls management plan in place, and this has been followed but the adult sustains a fall resulting in harm | | | | **CONSIDER A LOW-LEVEL CONCERN** |

# Integrated approach to the management of an acute fall for home dwelling patients

South West Yorkshire Partnership NHS Foundation Trust




With **all of us** in mind.

***Medication key:**

**Common anticoagulants oral / injectable**

Warfarin
Apixaban
Edoxaban
Dabigatran
Rivaroxaban
LMW Heparins e.g. Tinzaparin, Enoxaparin, Dalteparin

**Common antiplatelets/combination therapy**

Clopidogrel
Clopidogrel +Aspirin
Aspirin + Ticagrelor

**This list is not exhaustive**

Call RCB for advice if needed.

*Reference: YAS Assessment Tools for patients who have fallen Clinical Directorate 30/11/2017. Version 4*

**Key:**

| | |
|---|---|
| **RCB** | Right Care Barnsley |
| **UCR** | Urgent community response |
| **NNS** | Neighbourhood nursing service |
| **NRS** | Neighbourhood rehabilitation service |
| **YAS** | Yorkshire Ambulance Service |

**Useful Numbers:**

**ALT** - 01226 775671
**RCB** - 01226 644575
**YAS clinical hub** - 0300 33 00 274

All information taken from NICE Guidance (NG232) 2023

Review date: November 2025

If you require a copy of this information in any other format or language please contact your line manager.

BARNSLEY Metropolitan Borough Council

NHS Yorkshire Ambulance Service NHS Trust

With **all of us** in mind.

JOB NO 4361 JUL24

# Integrated approach to the management of an acute fall in care homes

**Falls definition: Unintentional landing on lower surface**

South West Yorkshire Partnership NHS Foundation Trust

Care home staff to do observations
(BP, pulse, sats, temp) and check for injury as per care home process

**Major Injury/illness****
e.g. Head injury and taking anticoagulants* , obvious bony deformity, severe pain, significant laceration/bleeding, reduced consciousness

Unwitnessed falls in those taking anticoagulants* where head injury cannot be excluded

**Minor injury / illness**
(no anticoagulants* OR witnessed fall with no head injury and taking anticoagulants*) e.g. No obvious bony deformity, superficial wound/minor skin tear, mild/ moderate pain, appears unwell

**Unhurt**
no anticoagulants* OR witnessed fall with no injury (including no head injury) in those taking anticoagulants*

Ring 999

Care home staff ensure individual is warm, comfortable and hydrated if appropriate (clear fluids only)

YAS attend and assess

YAS convey

Acute care

Refer to RCB

RCB call 999

Major injury/illness suspected – YAS required

Get individual up from floor if safe to do so using appropriate moving & handling method from their care plan

Call to RCB by care home staff for triage and onward referral as appropriate

Get individual up from floor if safe to do so using appropriate moving and handling method from the individual's care plan

Care staff to review individual's function, behaviour and mobility. If all normal for individual - monitor. Seek advice from RCB/999 as appropriate, if any concerns

Care homes to report fall to care co-ordinator for discussion at care home MDT

**Referral routed via RCB for further falls assessment / intervention as indicated e.g:**

| | |
|---|---|
| **GP** | General practitioner |
| **NNS** | District nurses / community matrons |
| **UCR** | Urgent community nursing response (24 hours a day) |
| **NRS** | Neighbourhood rehabilitation service - acute or enduring therapy needs and therapy crisis support, 8am – 5.30pm (referral required before 3:30pm) |
| **RCB** | Follow up phone call |
| **ASC** | Adult social care safeguarding |

**Safeguarding**

Care home staff to consider any safeguarding risks relating to the fall and take appropriate action in accordance with the Decision Support Guidance and/or any specific advice from adult social care

Care home staff to discuss all individuals who fall, including those who have repeated falls, with other professionals at the care home MDT.

**RCB hours:**
8am to 8pm then lines divert to UCR Mobile One for out of hours

***Medication key:**

**Common anticoagulants oral / injectable**

Warfarin
Apixaban
Edoxaban
Dabigatran
Rivaroxaban
LMW Heparins e.g. Tinzaparin, Enoxaparin, Dalteparin

**Common antiplatelets/combination therapy**

Clopidogrel
Clopidogrel +Aspirin
Aspirin + Ticagrelor

**This list is not exhaustive**

Call RCB for advice if needed.

*Reference: YAS Assessment Tools for patients who have fallen Clinical Directorate 30/11/2017. Version 4*

** For those individuals deemed not to have capacity and where there are advanced care planning documents in place, the contents of these should be taken into account to guide decision making in the patients best interests.

**Key:**

| | |
|---|---|
| **RCB** | Right Care Barnsley |
| **UCR** | Urgent community response |
| **NNS** | Neighbourhood nursing service |
| **NRS** | Neighbourhood rehabilitation service |
| **YAS** | Yorkshire Ambulance Service |

All information taken from NICE Guidance (NG232) 2023

Review date: November 2025

If you require a copy of this information in any other format or language please contact your line manager.

BARNSLEY Metropolitan Borough Council

NHS Yorkshire Ambulance Service NHS Trust

With **all of us** in mind.

JOB NO 4361 JUL24

**Appendix 2 – medication protocol**

BARNSLEY SAFEGUARDING ADULTS BOARD

# Protocol for Medication Incidents and Adult Safeguarding

Document Control

| | |
|---|---|
| Version | V1 draft |
| Date written | June 2024 |
| Name of originator/author | C.Erine- Safeguarding Adult Board Manager<br>E. Camody- Lead Pharmacist<br>G. Pepper- Safeguarding Adult Nurse Specialist |
| Approval date | TBC |
| Date issued | TBC |
| Review date | June 2027 |
| Target audience | Care Home Providers, Domiciliary Care Providers, Adult Social Care |

# Introduction

For those adults that need to take medication to maintain their health and wellbeing, it is essential to ensure that the adult has the right level of medication and has access to medication when necessary.

It is also important that medication is not given without consent. If the adult is unable to consent, then the persons mental capacity to make that decision must be assessed and clearly documented. If the person lacks mental capacity to make the decision, the decision must be taken in the person's best interest. This must be documented in the plan of care. Further information on the use of covert medication can be found under further resources at the end of this document. All providers should have a policy in place for covert medication.

An incident involving medication should be seen as an event that needs **questioning and investigating and recording** to prevent future occurrence.

Providers are expected to have systems in place to monitor and record any incidents which occur and their decision making around whether this constitutes abuse or neglect. If a medication incident does not trigger a safeguarding concern, action must be taken to address the issue. Acting in response to all medication incidents can reduce the risk of reoccurrence and improves practice. Such action may include undertaking an audit of practice and process and then sharing learning.

Abuse and neglect does not need to be intentional, or for example it could be a lack of action over repeated medication incidents.

Prevention of medication incidents should be the aim, and this is underpinned by appropriately trained staff, who are competent in their role, robust procedures, learning and actions from incidents and near miss medication incidents.

This protocol aims to enable providers to make a professional judgment about whether there is an indication that abuse, or neglect has occurred. A safeguarding adult concern must be reported to Barnsley Adult Social Care when a resident or service user experiences a medication incident and abuse and or neglect by a worker feature in circumstances surrounding the incident.

The protocol applies to people in receipt of care in care homes and domiciliary care.

You must ensure there is clear documentation to explain when the decision is made not to report a medication incident as a safeguarding concern.

This protocol only covers the decision making in relation to adult safeguarding concerns following a medication incident and you must still follow your organisation's process around informing the person's family, the Care Quality Commission, or requirements from Barnsley Adult Joint Commissioning (AJC).

If you need support or advice about whether to make a safeguarding referral, contact Adult Social Care on 01226 773300 https://www.barnsley.gov.uk/services/children-families-and-education/safeguarding-families-in-barnsley/safeguarding-adults-in-barnsley/for-professionals-and-volunteers-who-safeguard-adults/ referral forms

All care providers who are subject to organisational abuse procedures and/ or an embargo **must** complete and submit a Low-Level concern form following **all** medication incidents as a minimum and follow this protocol to guide whether to report a safeguarding concern. All other providers can use this guidance and professional judgement to determine if a safeguarding referral is appropriate.

This protocol does not cover when an adult is refusing medication because of self-neglect. In such cases the Barnsley Adult Board Self neglect and Hoarding Policy must be followed.

Barnsley SN & Hoarding Policy

If the medication incident involves staff from outside your organisation, for example a community pharmacists or GP surgery, a safeguarding referral must be made as this may impact on adults at risk outside your organisation.

This tool is to aid decision making about medication incidents and safeguarding concerns. These are just a few examples, and this does not replace professional judgement or aim to set a rigid criterion for intervention. It helps you consider the type of abuse and the circumstances in which a safeguarding concern should be reported to the local authority.

| | |
|---|---|
| A one-off isolated incident around medication where the adult has not come to any harm.<br><br>The medication error was not deliberate.<br><br>Appropriate action is being taken to mitigate future risks. | **A SAFEGUARDING OR LOW-LEVEL CONCERN IS UNLIKELY TO BE REQUIRED. HOWEVER PROFESSIONAL JUDGEMENT MUST BE APPLIED. CARE PROVIDERS SUBJECT TO EMBARGOS OR IN ORGANSATIONAL ABUSE ENQUIRIES MUST SUMBIT A LOW-LEVEL CONCERN** |

| | |
|---|---|
| **The incident only needs to meet one of the below.**<br><br>Reoccurring medication errors. Reoccurring means there is a pattern of incidents with similar underlying causes, and it is believed action could have been taken to prevent further incidents after the initial incident, however this hasn't happened or hasn't worked.<br><br>One off medication error for more than one person. (e.g., a whole medication round missed or delayed<br><br>The person has come to harm or was distressed by the incident.<br><br>The incident appears to be deliberate or has been covered up such as the falsifying of documentation.<br><br>Covert medication administration without necessary documentation being completed (Mental capacity assessment and best interest decision)<br><br>Deliberate withholding of medication with no medical reason | **REPORT AS A SAFEGUARDING CONCERN** |

| | |
|---|---|
| Consecutive/multiple medication incidents involving the same client (e.g., prescribed medication is not administered over more than one round because it has not been ordered or collected).<br><br>Multiple/repeat incidents within the same service, or by the same perpetrator (e.g., medication is administered incorrectly by a specific member of staff on more than one occasion).<br><br>The incorrect use of medication for reasons other than the benefit of the person.<br><br>Deliberate attempt to harm through use of a medicine.<br><br>Previous concerns identified and corrective action is not maintained.<br><br>Insufficient prevention measures in place such as training, supervision, and auditing | |

**Further resources**

Section 1.15 of this guideline provides advice for care home staff on covert administration of medicines to residents: National Institute for Health and Care Excellence (NICE): Social care guideline (SC1): Managing medicines in care homes.

Section 1.8 provides guidance to support care workers with the decision making and process for covert administration of medicines: National Institute for Health and Care Excellence (NICE) Guideline (NG67): Managing medicines for adults receiving social care in the community.
The Care Quality Commission includes advice for care homes on the use of covert medicines.

## Appendix 3 – Low Level concern form

***By completing this form, you are confirming that the incidents reported do not concern full safeguarding and that if they do, you have reported these directly to the Barnsley Council – Contact Centre (01226) 773300***

***If you are uncertain whether the incident requires a full Safeguarding Form, please phone us to confirm***

# Low-Level Safeguarding Concern Form

## *1. Social Care Provider Referral Information*

***To be completed by the person submitting the form***

***Date form completed:***

***1.1 Provider/Individual details:***

Name of Provider:

Individuals Name:

Individuals DOB:

Female/Male:

Date of concern(s):

If multiple dates, please enter further details below:

Does the personal have mental capacity?
Yes / No

If no, has the Person's Representative been notified?
Yes / No

## *1.2 Concern Details:*

### *Type of concern:*

Moving and Handling – No Injury ☐

Unwitnessed Fall – No Injury ☐

Resident on Resident – No Injury ☐

Incorrect Medication – No Negative Impact ☐

Medication Missed – No Negative Impact ☐

Other ☐

If other please provide details:

| | |
|---|---|
| ***Please Summarise the incident:*** | |
| Did you witness/hear the incident of concern? | |
| Who reported the incident to you? | |
| | |
| What time did the incident occur? *(Breakfast / AM / Lunch / Dinner / PM / Tea / Evening / Overnight / Other / Specific Time)* | Choose an item |
| *If 'Other' or specific time, please detail* | |
| | |
| Was there a recent discharge from any health and care services? (Hospital / Mental Health Services / OT / Social Care Services / Other) | Choose an item |
| If 'Other' please detail | |
| When was this discharge? ( In the last 48 hours / In the last week / In the last two weeks / In the last Month / Longer | Choose an item |
| | |
| **Have the Care Plans and Risk Assessment been updated to reflect the incident?** | |
| *(Please note the above may be requested)* | |
| ***1.2.1 Unwitnessed Falls Additional Information*** | |
| *(Only complete if Unwitnessed Fall)* | |
| **Does the person have a Falls History?** | Yes / No |
| If yes, please provide details | |

| **Are there any health conditions that affect Mobility? (Tick all that apply)** | | | |
|---|---|---|---|
| Any muscle weakness and/or poor balance | ☐ | High / Low Blood Pressure | ☐ |
| Alcohol Misuse | ☐ | Visual Impairment | ☐ |
| Any depression | ☐ | Issues with footcare | ☐ |
| Infection | ☐ | Changes to Medication | ☐ |
| Multi-morbidity / frailty | ☐ | Any changes in cognitive impairment | ☐ |
| *Other Please Provide Details* | | | |
| **Is the person taking any MEDICATION that may have contributed?** | | Yes / No | |
| *If yes, please provide details* | | | |
| **Are there any relevant ENVIRONMENTAL FACTORS?** | | Yes / No | |
| *If yes, please provide details* | | | |
| **Has there been any CHANGES TO FOOTWEAR because of this fall?** | | Yes / No | |
| *If yes, please provide details* | | | |
| **How were they raised from the floor?** | | Independently / With Assistance | |
| Please provide details | | | |

## 1.3 Finalising the Referral

| | |
|---|---|
| *Who is completing this form?* | |
| Name: | |
| Job title: | |
| Tel: | |
| Address: | |
| Email Address: | |
| Date: | |

***Please email this form to adultsocialservices@barnsley.gov.uk***