Richmond and Wandsworth Safeguarding Adults Board

Guidance on

Safeguarding Incidents Patient to Patient in Hospital Setting

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1. Introduction

1.1. The Care Act 2014 defines Safeguarding as 'protecting an adult's right to live in safety, free from abuse and neglect'. Adult safeguarding is about preventing and responding to concerns of abuse, harm or neglect of adults.

1.2. The Safeguarding duties apply to adults who have needs for care or support (whether or not the local authority is meeting any of those needs) and; is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect. [DOH Care and Support Statutory Guidance, October 2014].

1.3. All notifiable incidents should be reported to the CQC in line with the requirements of the Health and Social Care Act 2008 Regulations 2014. The law requires these notifications to be submitted within certain timescales – further guidance is available on what should be reported, how and in what timescales via the CQC guidance on Statutory Notifications.

1.4. This protocol provides guidance for health and social care staff to identify when a patient to patient incidents should trigger a safeguarding alert. The threshold for raising safeguarding alerts is purposefully low, all alerts will then be triaged in line with the safeguarding process and a proportionate response will be decided in line with the available evidence and the Making Safeguarding Personal approach.

2. Context

2.1. The Care Act 2014 sets out statutory responsibility for the integration of care and support between health and local authorities. NHS England and Clinical Commissioning Groups are working in partnership with local and neighbouring social care services. Local Authorities have statutory responsibility for safeguarding. This guidance is to support staff in understanding criteria for safeguarding in relation to patient to patient incidents in a hospital setting.

2.2. The current number of safeguarding concerns related to inpatient incidents across Richmond &Wandsworth is approximately 20 to 25 a week of which approximately 70% are not progressed.

2.3. This local practice guidance supplements the London Multi-agency Policy and Procedures to Safeguard Adults from Abuse and reflects the local guidance for responding to concerns, whether S42 is required or not and the link with other parallel inquires.

2.4. Local Authority and NHS partnerships 'Local Authorities can continue to enter into partnership arrangements with the NHS for the NHS to carry out a Local Authority's 'health-related functions' (as defined in the 2000 Regulations [the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000). This effectively authorises NHS bodies to exercise those prescribed functions, including adult safeguarding functions. These arrangements are 'partnership arrangements' rather than 'delegations. The Local Authority would still remain legally responsible for how its functions (including adult safeguarding) are carried out via partnership arrangements.' (Department of Health March 2015). Within this policy and procedure,

where there are partnership agreements under Section 75 of the NHS Act 2006 with Mental Health Trusts, appropriately trained managers within the Trust can act on behalf of the Local Authority to undertake adult safeguarding duties. Where this is done, the legal responsibility for safeguarding remains with the Local Authority.

2.5. Accountability and Assurance Framework (2015), sets out the safeguarding roles, duties and responsibilities of all organisations in the NHS.

3. NHS Patient Safety Incidents Reporting

3.1. Health providers do record all patient safety incidents on their local risk management systems. These reports will then be routinely uploaded to the National Reporting and Learning System (NRLS) to support national learning. Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare.

3.2. Patient safety review and response reports outline identified issues and risks and the actions taken as a direct result to protect patients from harm. Reporting all patient safety incidents, whether they result in harm or not, is fundamental to improving patient safety. The national action we take as a result of what we learn from incident reports is vital in protecting patients across the NHS from harm.

3.3. Health providers staff and their managers have a duty to monitor the frequency and types of accidents and untoward incidents which occur to patients in their care as well as for incidents involving aggression and self-harm. Possible reasons and findings are agreed, and recommendations made.

4. Safeguarding Criteria

4.1. If a local authority has reasonable cause to suspect an adult in its area is suffering or is at risk of abuse and neglect and has needs which leave him or her unable to protect himself or herself, then it must ensure enquiries are made in order to decide what action (if any) should be taken, and by whom. Enquiries should be made by the most appropriate professional, and in some circumstances that will be a health professional. In discharging these duties, there are express reciprocal duties to co-operate on local authorities and their “relevant partners”, and that category includes NHS England, and all CCGs and health trusts in the local authority’s area.

4.2. The safety of an adult at risk is of paramount importance. Immediate action may be required to safeguard investigations and any other children, young people or adults at risk. Any concern that children, young people or adults may be at risk of harm or abuse, must immediately be reported.

5. Incidents Between Vulnerable Adults

5.1. There may be times when the behaviour of an adult at risk towards another is abusive. Any person at risk of abuse from another is in need of protection. In deciding how to manage such incidents it is important to consider whether harm has occurred and if so, whether this amounts to a crime requiring the involvement of the Police.

6. Prevention

6.1. Prevention is always the preferred option and service providers should plan the care and support they offer so that opportunities for incidents between people using the service are minimised. People using services such as day centres, care homes and supported housing have the right to be supported in a safe environment; abuse by another adult at risk is just as harmful as abuse by anyone else.

6.2. Good practice would indicate that when people are meaningfully engaged in activities, which they enjoy then the likelihood of incidents occurring is reduced.

6.3. Services should plan via an assessment of needs and risks how best to support individuals. Early intervention with service users who challenge is important in order to prevent any escalation of behaviours. Individuals with known behavioural management problems should have their needs identified and measures put in place to properly support them and maximise their quality of life; records should include a history of the person's behaviours.

6.4. Where behaviour problems are identified services should ensure that staff have access to specialised training. It is important that individual care plans/support plans are properly implemented by staff to ensure that any potential for abusive behaviour is managed appropriately and risks are minimised.

7. Response Levels

7.1. In deciding the appropriate response when an incident has occurred, a risk assessment should be carried out. Factors to consider will include:

- The vulnerability and capacity of the individuals involved
- The nature and extent of the abuse – has significant harm occurred?
- Whether it is a 'one-off' or a repeat incident
- The impact on the individual and their independence
- The risk of repeated or increasingly serious acts
- Whether the incident amounts to a crime
- The views of the person or their representative

7.2. Risk assessment is the process of evaluating these factors to aid decision-making, which is **risk management.**

7.3. A key factor in the deciding how to respond is whether harm has occurred. This requires careful person-centred assessment and, if appropriate, consultation with them and the people close to them. The impact of an incident can range from no effect to serious physical injury or emotional distress which damages the person's quality of life.

7.4. If it was an isolated incident and no harm has occurred, then there is no requirement to raise a Safeguarding Concern. Nor is there a need to report such incidents through the Provider-led enquiry (Service Concern) process. It is the responsibility of the Provider Manager to ensure that a risk assessment is in place to ensure the

immediate safety of all users of the service and to review the support of the individuals involved in the incident.

7.5. When an incident has had a significant impact on an individual's wellbeing, a Safeguarding Concern must be reported. **Any serious sexual or physical assault will require the involvement of police.**

7.6. Where the person causing the harm is also an adult at risk, agencies must be careful not to overlook their duty of care to them. A re-assessment of need must be carried out and the care or support plan should ensure that safeguards are in place to prevent repeat incidents.

Appendix 1: Responses Levels

Incidents involving another person with care & support needs	
Non-reportable Near miss/No Harm – Low Risk	**Reportable** Moderate/Significant Harm Incidents
Types of Incidents • One off incident with no or little harm, i.e. lesion/cut) accident/clinical account injury. • Dispute with fellow service users, no harm quickly resolved and risk assessment/management plan in place. • Minor lesion/cut/bruise with no verifiable account of injury • One off assault with minor injury (marks, lesions, minor cuts) • More than one assault with minor injury (marks, lesions, minor cuts). • Un-witnessed fall • Isolated incident involving service user on service user	**Types of Incidents** • Inappropriate restraint. • Unexplained serious injuries. • Witnessed assault causing serious injury. • Multiple minor bruises, lesions/cuts or grip marks. • Withholding food, fluids or aids i.e. mobility/hearing aids. • Allegation of assault by staff. • Incidents of assault of a repeat nature • Serious physical assault • Actual or grievous bodily harm • Irreversible injuries sustained • Allegation of sexual assault • Assisted Suicide