AA Healthcare Services Ltd

SAFEGUARDING VULNERABLE SERVICE USERS' POLICY

Contents

The safeguarding policy of **AA HEALTHCARE SERVICES LTD** falls under the jurisdiction of regulation 13 of the Health and Social Care Act 2008/2014 regulations. The intention of this regulation is to safeguard people who use our services from suffering any form of abuse or improper treatment while receiving care. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. To meet the requirements of this regulation, **AA HEALTHCARE SERVICES LTD** has a zero-tolerance approach to abuse, unlawful discrimination and restraint.

This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

AA HEALTHCARE SERVICES LTD has robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors. Abuse and improper treatment include Care or treatment that is degrading for service users and Care or treatment that significantly disregards their needs or that involves inappropriate recourse to restraint. For these purposes, 'restraint' includes the use or threat of force, and physical, chemical or mechanical methods of restricting liberty to overcome a person's resistance to the treatment in question. Where any form of abuse is suspected, occurs, is discovered, or reported by a third-party **AA HEALTHCARE SERVICES LTD** will take appropriate action without delay. This action includes investigation and/or referral to the appropriate body. This applies whether the third party reporting an occurrence is internal or external to **AA HEALTHCARE SERVICES LTD** Domiciliary Care.

This Policy defines the arrangements and procedures in place within the **AA HEALTHCARE SERVICES LTD** that ensures the safeguarding of vulnerable service users from abuse, avoidable harm and exploitation. This Policy is intended to also

comply with guidance of The Care Act 2014 and the Human Rights Act 1998, as they apply to **AA HEALTHCARE SERVICES LTD** business approach to safeguarding.

There is a legal requirement to register as a service provider with the CQC where a regulated activity is being carried out and as such, it is a criminal offense to carry out a regulated activity without being registered under Section 10(1) of the Health and Social Care Act 2008. This offense can be dealt with by the Magistrates or Crown Court and if found guilty, the court can impose an unlimited fine and/or a sentence of up to 12 months' imprisonment. **The regulated activity of personal care may not be provided without the required registration with CQC and failure to comply may constitute a safeguarding infringement.**

SIX PRINCIPLES OF SAFEGUARDING

Our safeguarding protocols are based on 6 key principles first introduced by the Department of Health in 2011, but now embedded in the Care Act, these six principles are:

1.Empowerment

People being encouraged to make their own decisions and informed consent. "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

2.Prevention

It is better to take action before harm occurs. – "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

3.Proportionality

The least intrusive response appropriate to the risk presented. "I am sure that the professionals will work for my best interests, as I see them and they will only get involved as much as I require."

4.Protection

Care and representation for those in greatest need. “I get help and care to report abuse. I get help to take part in the safeguarding process to the extent to which I want and to which I am able.”

5.Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. “I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together to get the best result for me.”

6.Accountability

Accountability and transparency in safeguarding practice. “I understand the role of everyone involved in my life.”

POLICY’S PRINCIPLES

It is the Policy at **AA HEALTHCARE SERVICES LTD** to develop and implement procedures and strategies which are designed to safeguard vulnerable service users from abuse, avoidable harm and exploitation. These strategies will:

- identify who is at risk;
- identify what is interpreted as abuse;
- identify the types of abuse that can occur;
- promote staff awareness of the common indicators associated with each type of abuse;
- prevent persons who do not possess an *DBS Disclosure from* being recruited;
- Specify the procedures to be followed in the event of alleged or suspected abuse (a “Concern”).

At the beginning of the Domiciliary Care Services Contract for Services Users, a risk assessment will have been carried out to identify situations where the service user can

be placed at undue risk within their own domestic environment through normal daily living activities. However, should this assessment identify situations where the service user is considered to be especially at risk through their vulnerability, then an additional Risk Assessment will be carried out.

This Policy will be accompanied by specialised staff training programs as an on-going process, and the organisation's Whistleblowing Policy to be embedded in the training.

Whistle-blowing Policy is a policy which sets out the values, principles and procedures underpinning **AA HEALTHCARE SERVICES LTD** approach to whistle-blowing in regards to safeguarding concerns and issues. The Domiciliary Care service understands "whistle-blowing" to refer to actions taken by an employee or employees to raise concerns about:

- alleged, suspected or observed malpractice.
- assessed, identified or perceived risks (e.g., to the safety of service users)
- unethical conduct or possible illegal acts.

Any of the above could harm, or create a risk of harm, to service users, colleagues or the general public.

The policy is in line with the Care Quality Commission (CQC) recommendations for the reporting of concerns about service user and the safeguarding provisions under Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The right to whistle blow is also built into the practice of "Good Governance" as described in Regulation 17, which requires us as the **AA HEALTHCARE SERVICES LTD** Care providers to be transparent and open and comply with the Public Disclosure Act 1998 (and as amended under the Enterprise and Regulatory Reform Act (ERRA) 2013).

The policy should be read and used to complement the Domiciliary Care Services' **complaints procedure**. The Domiciliary Care service recognises that "whistle-blowing" is distinct from a complaint in that "whistle-blowers" raise their concerns as employees. Complaints about a service are raised by service users, others acting on their behalf or members of the public. However, it is recognised that similar procedures should be are followed to respond to complaints and whistle-blowing.

DEFINITION OF ABUSE:

'Abuse' means—any behaviour towards a service user that is an offence under the Sexual Offences Act 2003(a), ill-treatment (whether of a physical or psychological nature) of a service user, theft, misuse or misappropriation of money or property belonging to a service user, or neglect of a service user. Abuse is a violation of an individual's human or civil rights by any other person or persons. For vulnerable service users this will focus upon others who have influence over them. These violations may be intentional or unintentional. These violations may be a single act, or a repetition of acts over a period of time.

DEFINITION OF A VULNERABLE SERVICE USER, OR SERVICE USER AT RISK:

- This refers to a person aged 18 or over, who has been assessed to have needs of community Domiciliary Care Services and who is experiencing abuse, or is judged to be at risk of abuse and neglect, and who is, or may be, unable to protect themselves from the risk, or experience, of significant harm, abuse or exploitation. This may be by reason of mental or other disability, age or illness.

This will apply whether or not the local authority is meeting any of these care needs.

IMPLICATIONS FOR STANDARDS OF CARE:

- Abuse reflects a lack of respect for an individual and is an infringement of their legal rights.
- This may be considered to be an abuse of power, and may constitute a criminal act.

- It is the treatment of an individual which causes significant harm, and can result in the deterioration of a person's physical, emotional, social and behavioural development.

INFLICTIONS OF ABUSE:

Abuse can be inflicted by the following persons:

- third parties – identity unknown;
- the service user/other service users
- self-inflicted abuse (this will include substance abuse and deliberate self-neglect);
- other parties in a professional or personal relationship (this will include those who deliberately set out to exploit vulnerable persons and who the service user regards these persons to be in a position of trust).

IDENTIFYING PEOPLE AT RISK OF ABUSE

Safeguarding is everybody's responsibility and at **AA HEALTHCARE SERVICES LTD** we are duty bound to confront abuse wherever it may be found. There are certain groups that are particularly vulnerable to risk of abuse owing to protected characteristics as detailed in the Equality Act 2010. These may be targeted on the grounds of: age, disability, gender reassignment, marriage or civil partnership (in employment only), pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Within our service specification we will pay particular attention to:

- People with learning disabilities
- Older service users
- Family care givers

TRAINING AND EDUCATION

AA HEALTHCARE SERVICES LTD shall recruit and train staff in the following safeguarding

- What is safeguarding adults
- How to care for vulnerable people
- How to keep people safe
- How to respond to safeguarding alerts
- The legislation surrounding safeguarding adults
- Understand the mental capacity act
- Understand the purpose of report writing
- How to plan an adult protection investigation
- How to provide strong leadership to make safeguarding integral to care
- How to use systems & standards to prevent and respond to neglect and abuse
- Training for service users with learning disabilities
- Training with other groups
- Staff training and education
- Training in communication
- Safeguarding Policies and procedures awareness
- A culture of zero tolerance
- Promoting positive practice
- Whistle blowing
- Choice and quality

- Care planning and risk assessment
- Recruitment, supervision and leadership
- Measures to prevent financial abuse

SAFEGUARDING ADULTS TRAINING COURSE FOR MANAGERS AND NEWLY APPOINTED SAFEGUARDING LEADS

We will also offer a specialist training course for senior managers or newly appointed safeguarding leads who are responsible for safeguarding adults from neglect and harm.

Content includes:

- identifying risk and vulnerability to abuse and neglect
- making safeguarding personal and applying principles in practice
- safeguarding duties for local authorities
- responsibilities for partners such as housing, police and health bodies
- the relevance of the Mental Capacity Act
- the importance of partnership working and information sharing
- how to respond to allegations, concerns and disclosures

TYPES OF ABUSE

The policy complies to the edicts of the Care Act 2014 regarding legislative framework and subsequently identifies ten types or categories of abuse, these are:

1. PHYSICAL ABUSE

Types of physical abuse include:

- Assault, hitting, slapping, punching, kicking, hair-pulling, biting, pushing the service user
- Rough handling

- Scalding and burning
- Physical punishments
- Inappropriate or unlawful use of restraint
- Making someone purposefully uncomfortable (e.g., opening a window and removing blankets)
- Involuntary isolation or confinement
- Misuse of medication (e.g., over-sedation)
- Forcible feeding or withholding food
- Unauthorised restraint, restricting movement (e.g., tying someone to a chair)

2. DOMESTIC VIOLENCE OR ABUSE

Domestic violence or abuse can be characterised by any of the indicators of abuse outlined in this briefing relating to the types of domestic abuse which include:

- psychological
- physical
- sexual
- financial
- emotional

3. SEXUAL ABUSE

Types of sexual abuse include:

- Rape, attempted rape or sexual assault
- Inappropriate touch anywhere
- Non- consensual masturbation of either or both persons

- Non- consensual sexual penetration or attempted penetration of the vagina, anus or mouth
- Any sexual activity that the person lacks the capacity to consent to
- Inappropriate looking, sexual teasing or innuendo or sexual harassment
- Sexual photography or forced use of pornography or witnessing of sexual acts
- Indecent exposure

4. PSYCHOLOGICAL OR EMOTIONAL ABUSE

Types of psychological or emotional abuse include:

- Enforced social isolation – preventing someone accessing services, educational and social opportunities and seeing friends
- Removing mobility or communication aids or intentionally leaving someone unattended when they need assistance
- Preventing someone from meeting their religious and cultural needs
- Preventing the expression of choice and opinion
- Failure to respect privacy
- Preventing stimulation, meaningful occupation or activities
- Intimidation, coercion, harassment, use of threats, humiliation, bullying, swearing or verbal abuse
- Addressing a person in a patronising or demeaning way
- Threats of harm or abandonment
- Cyber bullying

5. FINANCIAL OR MATERIAL ABUSE

Types of financial or material abuse include:

- Theft of money or possessions
- Fraud, scamming
- Preventing a person from accessing their own money, benefits or assets
- Employees taking a loan from a person using the service
- Undue pressure, duress, threat or undue influence put on the person in connection with loans, wills, property, inheritance or financial transactions
- Arranging less care than is needed to save money to maximise inheritance
- Denying assistance to manage/monitor financial affairs
- Denying assistance to access benefits
- Misuse of personal allowance in Domiciliary Care Services
- Misuse of benefits or direct payments in a family home
- Someone moving into a service user's residence and living rent free without agreement or under duress
- False representation, using another person's bank account, cards or documents
- Exploitation of a person's money or assets, e.g., unauthorised use of a car
- Misuse of a power of attorney, deputy, appointee-ship or other legal authority
- Rogue trading e.g., unnecessary or overpriced property repairs and failure to carry out agreed repairs or poor workmanship

6. MODERN SLAVERY

Types of modern slavery include:

- Human trafficking
- Forced labour

- Domestic servitude
- Sexual exploitation, such as escort work, prostitution and pornography
- Debt bondage – being forced to work to pay off debts that realistically they never will be able to.

7. DISCRIMINATORY ABUSE

Types of discriminatory abuse include:

- Unequal treatment based on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex or sexual orientation (known as **'protected characteristics' under the Equality Act 2010**)
- Verbal abuse, derogatory remarks or inappropriate use of language related to a protected characteristic
- Denying access to communication aids, not allowing access to an interpreter, signer or lip-reader
- Harassment or deliberate exclusion on the grounds of a protected characteristic
- Denying basic rights to healthcare, education, employment and criminal justice relating to a protected characteristic
- Substandard service provision relating to a protected characteristic

8.ORGANISATIONAL OR INSTITUTIONAL ABUSE

Types of organisational or institutional abuse include:

- Discouraging visits or the involvement of relatives or friends
- Run-down or overcrowded establishment
- Authoritarian management or rigid regimes
- Lack of leadership and supervision

- Insufficient staff or high turnover resulting in poor quality Domiciliary Care
- Abusive and disrespectful attitudes towards people using the service
- Inappropriate use of restraints
- Lack of respect for dignity and privacy
- Failure to manage residents with abusive behaviour
- Not providing adequate food and drink, or assistance with eating
- Not offering choice or promoting independence
- Misuse of medication
- Failure to provide care with dentures, spectacles or hearing aids
- Not taking account of individuals' cultural, religious or ethnic needs
- Failure to respond to abuse appropriately
- Interference with personal correspondence or communication
- Failure to respond to complaints

9.NEGLECT OR ACTS OF OMISSION

Types of neglect and acts of omission include:

- Failure to provide or allow access to food, shelter, clothing, heating, stimulation and activity, personal or medical care
- Providing care in a way that the person dislikes
- Failure to administer medication as prescribed
- Refusal of access to visitors
- Not taking account of individuals' cultural, religious or ethnic needs
- Not taking account of educational, social and recreational needs

- Ignoring or isolating the person
- Preventing the person from making their own decisions
- Preventing access to glasses, hearing aids, dentures, etc.
- Failure to ensure privacy and dignity

10.SELF-NEGLECT

Types of self-neglect include:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid self-harm
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

11.COERCIVE/CONTROLLING BEHAVIOUR

This type of abuse includes:

- Acts of assault, threats, humiliation and intimidation
- Harming, punishing, or frightening the person
- Isolating the person from sources of care
- Exploitation of resources or money
- Preventing the person from escaping abuse
- Regulating everyday behaviour

SYMPTOMS / INDICATORS OF ABUSE

Our Domiciliary Care Services staff at **AA HEALTHCARE SERVICES LTD** shall receive appropriate training in the detection of abuse through symptoms, indicators

and behaviour of the service user. Some of these indicators are summarised as follows:

PHYSICAL ABUSE (INTENTIONAL OR UNINTENTIONAL):

- No explanation for injuries (clusters of injuries) or inconsistency with the account of what happened
- Injuries are inconsistent with the person's lifestyle
- Bruising, cuts, welts, burns (particularly cigarette burns) and/or marks on the body or loss of hair in clumps
- Frequent injuries
- Unexplained falls
- Subdued or changed behaviour in the presence of a particular person
- Signs of malnutrition
- Failure to seek medical treatment or frequent changes of GP
- Pushing or rough handling of a vulnerable person;
- Deprivation of clothing, warmth or basic health care needs;
- Sudden / unexplained weight loss;
- Female genital mutilation (abbreviated to "FGM")

DOMESTIC VIOLENCE:

- Low self-esteem
- Feeling that the abuse is their fault when it is not
- Physical evidence of violence such as bruising, cuts, broken bones
- Verbal abuse and humiliation in front of others
- Fear of outside intervention

- Damage to home or property
- Isolation – not seeing friends and family
- Limited access to money

SEXUAL ABUSE:

- Bruising, particularly to the thighs, buttocks and upper arms and marks on the neck
- Torn, stained or bloody underclothing
- Bleeding, pain or itching in the genital area
- Unusual difficulty in walking or sitting
- Infections, unexplained genital discharge, or sexually transmitted diseases
- Pregnancy in a woman who is unable to consent to sexual intercourse
- The uncharacteristic use of explicit sexual language or significant changes in sexual behaviour or attitude
- Incontinence not related to any medical diagnosis
- Self-harming
- Poor concentration, withdrawal, sleep disturbance
- Excessive fear/apprehension of, or withdrawal from, relationships
- Fear of receiving help with personal care
- Reluctance to be alone with a particular person

PSYCHOLOGICAL EMOTIONAL ABUSE:

- An air of silence when a particular person is present
- Withdrawal or change in the psychological state of the person
- Insomnia

- Low self-esteem
- Uncooperative and aggressive behaviour
- A change of appetite, weight loss/gain
- Signs of distress: fearfulness, anger
- Apparent false claims, by someone involved with the person, to attract unnecessary treatment

FINANCIAL/MATERIAL ABUSE:

- Missing personal possessions
- Unexplained lack of money or inability to maintain lifestyle
- Unexplained withdrawal of funds from accounts
- Power of attorney or lasting power of attorney (LPA) being obtained after the person has ceased to have mental capacity
- Failure to register an LPA after the person has ceased to have mental capacity to manage their finances, so that it appears that they are continuing to do so
- The person allocated to manage financial affairs is evasive or uncooperative
- The family or others show unusual interest in the assets of the person
- Signs of financial hardship in cases where the person's financial affairs are being managed by a court appointed deputy, attorney or LPA
- Recent changes in deeds or title to property
- Rent arrears and eviction notices
- A lack of clear financial accounts held by a care home or service
- Failure to provide receipts for shopping or other financial transactions carried out on behalf of the person

- Disparity between the person's living conditions and their financial resources, e.g., insufficient food in the house
- Unnecessary property repairs

MODERN SLAVERY

- Signs of physical or emotional abuse
- Appearing to be malnourished, unkempt or withdrawn
- Isolation from the community, seeming under the control or influence of others
- Living in dirty, cramped or overcrowded accommodation and or living and working at the same address
- Lack of personal effects or identification documents
- Always wearing the same clothes
- Avoidance of eye contact, appearing frightened or hesitant to talk to strangers
- Fear of law enforcers

DISCRIMINATORY ABUSE:

- The person appears withdrawn and isolated
- Expressions of anger, frustration, fear or anxiety

ORGANISATIONAL AND INSTITUTIONAL ABUSE:

- Lack of flexibility and choice for people using the service
- Inadequate staffing levels
- People being hungry or dehydrated
- Poor standards of care
- Lack of personal clothing and possessions and communal use of personal items

- Lack of adequate procedures
- Poor record-keeping and missing documents
- Absence of visitors
- Few social, recreational and educational activities
- Public discussion of personal matters
- Unnecessary exposure during bathing or using the toilet
- Absence of individual care plans
- Lack of management overview and care

NEGLECT AND ACTS OF OMISSIONS:

- Poor environment – dirty or unhygienic
- Poor physical condition and/or personal hygiene
- Pressure sores or ulcers
- Malnutrition or unexplained weight loss
- Untreated injuries and medical problems
- Inconsistent or reluctant contact with medical and social care organisations
- Accumulation of untaken medication
- Uncharacteristic failure to engage in social interaction
- Inappropriate or inadequate clothing

SELF-NEGLECT:

- Very poor personal hygiene
- Unkempt appearance
- Lack of essential food, clothing or shelter

- Malnutrition and/or dehydration
- Living in squalid or unsanitary conditions
- Neglecting household maintenance
- Substance abuse;
- Ignoring personal administration issues (Utility Bills, services);
- Hoarding
- Collecting a large number of animals in inappropriate conditions
- Non-compliance with health or care services
- Inability or unwillingness to take medication or treat illness or injury

DOMESTIC VIOLENCE

- Evidence of violence or physical abuse by an intimate partner or relative;
- Evidence of violence or psychological, sexual, or financial abuse by an intimate partner or relative;
- So-called “honour” based violence;

MODERN SLAVERY:

- Evidence of coercion into a life of inhumane treatment (forced labour or domestic servitude);
- Evidence of human trafficking;
- Evidence of coercion into joining radical groups promoting violence;
- Forced / arranged marriage (with appropriate regard to ethnic and cultural considerations)

SCOPE OF SPECIFIC SAFEGUARDING POLICIES

Safeguarding a child – a child or young person means anyone under the age of 18 – this means protecting individual children from abuse and maltreatment or preventing harm to children's health or development

Safeguarding adults at risk – is anyone over the age of 18 who is at risk of harm and is in need of care to live in safety, free from abuse and neglect.

This safeguarding policy works in tandem with child specific safeguarding policies which include:

- Policy 04-3601 - Safeguarding the Child – Principles
- Policy 04-3602 – Bullying
- Policy 04-3603 - Allegations against Staff Member
- Policy 04-3604 - Internet Policy
- Policy 04-3605 - Illicit Substances Policy
- Policy 04-3606 - Missing Items & Suspected Theft
- Policy 04-3607 - Policy on MCA
- Policy 04-3608 - MCA Assessment & Review – Child
- Policy 04-3609 - DOL Safeguards – MCA
- Policy 04-3611 - Abuse & Violence by Child
- Policy 04-3612 - Challenging Behaviour
- Policy 04-3613 - Physical Intervention
- Policy 04-3614 - Unauthorised Absence of a Child
- Policy 04-3615 – PREVENT
- Policy 04-3616 - Room Search Policy

Preventive Measures:

Effective prevention in safeguarding needs to be broadly defined and should include all social care user groups and service configurations. It does not mean being over-protective or risk-averse.

Some of the most common prevention interventions for vulnerable service users include training and education of vulnerable service users and staff on abuse in order to help them to recognise and respond to abuse.

Other approaches include: identifying people at risk of abuse; awareness raising; information, advice and advocacy; policies and procedures; community links; legislation and regulation; interagency collaboration and a general emphasis on promoting empowerment and choice.

AA HEALTHCARE SERVICES LTD procedure for recruiting Domiciliary Care Services staff includes a rigorous check, through the Disclosure& Barring Service (DBS), on the suitability of each individual who is being considered for recruitment into a Care Worker position where he/she may be caring for vulnerable service users.

In accordance with statutory requirements, the organisation will not recruit any individual who does not possess an enhanced CRB Certificate through the DBS.

As detailed earlier each Care Worker will receive training in Awareness of Vulnerable Service User Abuse, and the measures to be taken if abuse is suspected. This will form an integral part of each staff member's on-going Training Plan.

Service User Risk Assessments:

Where considered appropriate, in order to assess and quantify the risks of abuse relating to a service user, a Risk Assessment will be undertaken.

This document provides for the following information to be recorded which will form the basis of any Action Plan that may be deemed appropriate:

Lists of the categories of abuse that may be relevant, Fundamental Risk Assessment information of **AA HEALTHCARE SERVICES LTD** will focus upon risk from 6 distinct standpoints which are:

- The kind of harm that has been threatened or inflicted; the severity / seriousness of the incident, and vulnerable service users is involved.
- Any evidence that the abuse may be repeated or escalate.
- The impact upon the person's independence, health and well-being.
- Any evidence that the abuse was premeditated, and accompanied by threats, coercion or violence.
- The length of time that the actual abuse has been happening, and whether there is a pattern of history for the service user at risk and / or the perpetrator alleged to be causing the harm.
- The kind of care that the service user at risk normally requires.

RAISING A CONCERN (ACTION TO BE TAKEN IN THE EVENT OF ALLEGED / SUSPECTED ABUSE):

The Registered Manager of **AA HEALTHCARE SERVICES LTD** is **Amisha Alicia Allison.**

She is designated as the **safeguarding lead** within the Organisation with direct responsibility for investigating any concern relevant to an alleged or suspected incident of abuse.

Any staff member with concerns regarding possible abuse of a vulnerable service user will report the matter directly to the Domiciliary Care Services Manager.

Where it is suspected that such abuse may be caused by another staff member then reporting the matter will be done in accordance with the Whistle-blowing Policy.

The safeguarding Lead will therefore have responsibility for dealing with allegations, concerns and disclosures of abuse and abusive practice. They will have responsibility for making referrals to statutory agencies such as the police and social services.

It will be the responsibility of this person to have a detailed knowledge of both referral systems to statutory agencies along the local service user protection process.

It would generally be the responsibility of this person to attend meetings under the service user protection process and take advice and guidance from the service user protection team at the local authority or Health and Social Care Trust.

Our Safeguarding Lead Officer at **AA HEALTHCARE SERVICES LTD, Amisha Alicia Allison** is also our Domiciliary Care Services Manager.

Reporting safeguarding matters will take into account the balance which needs to be maintained for the confidentiality of the service user's affairs and the duty of care to report suspected abuse.

In all cases, the Safeguarding Lead is responsible for maintaining complete case records of the suspicions raised, or allegations made, including dates, times and persons involved, and action taken. If a service user has got a concern that someone is being abused or neglected, it is important that they raise that concern internally, in line with **AA HEALTHCARE SERVICES LTD** policy and procedure. This issue is reported to our Nominated Safeguarding Lead Officer. She can be contacted at:

Contact address details:

AA HEALTHCARE SERVICES LTD

Flat L30,

Goldsworthy Gardens,

London,

England,

SE16 2TB

Email: info@aahealth-care.co.uk

Phone: 07908515255

The organisation's safeguarding lead will then consult the service user where possible and gain their consent to report to external authorities such as the local authority. If the person does not consent, managers will decide whether there are grounds for overriding consent.

Here are some **AA HEALTHCARE SERVICES LTD** useful dos and don’ts in this regard:

Do

- Act on any concerns, suspicions or doubts.
- In an emergency, if there is actual or immediate risk of abuse, call 999.
- Try to ensure the immediate safety of those concerned – but not at the risk of your own safety.
- Provide first aid if necessary and someone is available with appropriate skills.
- Listen and clarify what the concern is / what has happened.
- Provide reassurance and comfort; offer a cup of tea.
- Assure the person that the matter will be taken seriously.
- Ask the person what they want done.
- Explain what you will need to do and who you may need to inform
- Try to gain consent to share information as necessary.
- Consider the person’s mental capacity to consent and seek assistance if you are uncertain.
- Actively preserve any evidence.
- Respect privacy as far as possible.
- Arrange care for the alleged victim.
- Contact the local authority children’s services if a child is, or may also be, at risk.
- Report all your concerns to a manager in line with organisational and local multi-agency procedures.

- Make an accurate record of what has occurred (or what has been disclosed/alleged) and what action has been taken.

DON'T

- Ignore
- Promise confidentiality – explain how and why the information might need to be shared.
- Rush the person.
- Probe or question – just record the facts and seek clarification where necessary.
- Contaminate or disturb any evidence.
- Interview witnesses – but do record any information volunteered by them.
- Panic or show shock /disbelief.
- Be judgmental.
- Jump to conclusions.
- Approach the alleged abuser (unless they also have care needs and are in your care or they are a member of your staff).
- Gossip, only inform others on a need-to-know basis.
- Put management or organisational interests before safety.

LOCAL AUTHORITY AND LOCAL AREA SAFEGUARDING DETAILS

The Care Act 2014 made all local authorities responsible for ensuring that any adult who needs care and who is at risk of or experiencing abuse or neglect, and as a result of their needs is unable to protect themselves, is protected by the local authority. To do this, local authorities have a Safeguarding Adults Board that coordinates local work to safeguard adults who need care. They're formed of a partnership between local commissioners and providers. They're led by the local authority with statutory

involvement of the police, local clinical commissioning groups and other organisations involved in caring vulnerable adults such as social care and health providers, probation and community rehabilitation companies, prisons, social housing, fire service and the voluntary and community sector. The board develops policies and procedures that all partners sign up to and agree to implement. It's also required to investigate, or ensure others do so, if it believes that an adult is, or is at risk of, abuse or neglect.

This means that the board could ask you to care or make enquires if abuse or neglect is reported within your service. You should make contact with your local board – they'll take the lead if there are any safeguarding concerns. **AA HEALTHCARE SERVICES LTD** shall work in liaison with the local Safeguarding Stakeholders. Therefore, whenever we shall have a safeguarding concern, we shall contact authorities:

Our local area safeguarding details are:

London Safeguarding Adults Board

Guildhall
PO Box 270 London
EC2P 2EJ (correspondence)
EC2V 7HH (visiting us)

Telephone: 020 7606 3030

ABUSE OF VULNERABLE SERVICE USERS (SERVICE USERS AT RISK) –AA HEALTHCARE SERVICES LTD's PROCEDURAL ACTIONS

AA HEALTHCARE SERVICES LTD has robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors.

This action may be of two types:

Corrective Action - action to be taken against perpetrators involved in confirmed incidents of abuse, with due consideration to the wishes of the abused. In all instances

the matter must be handled discreetly and sensitively. This may or may not involve the Registration Authority;

Preventive Action - strategies to be implemented with the objective of halting further abuse. Where such cases have involved the Organisation's staff, with resulting disciplinary measures taken, this will trigger a robust review of current practices and procedures to determine what additional protective measures, if any, need to be incorporated into the Organisation's systems.

Incidents of alleged / confirmed abuse will be logged and reviewed at the Quality Management Review Meetings for possible adverse trends.

If a staff member at **AA HEALTHCARE SERVICES LTD** witnesses abuse, they should intervene and challenge the behaviour only if it is safe to do so.

In all cases of disclosure, observation or suspicion, the staff member involved will follow the procedure summarised below:

Procedure for staff action

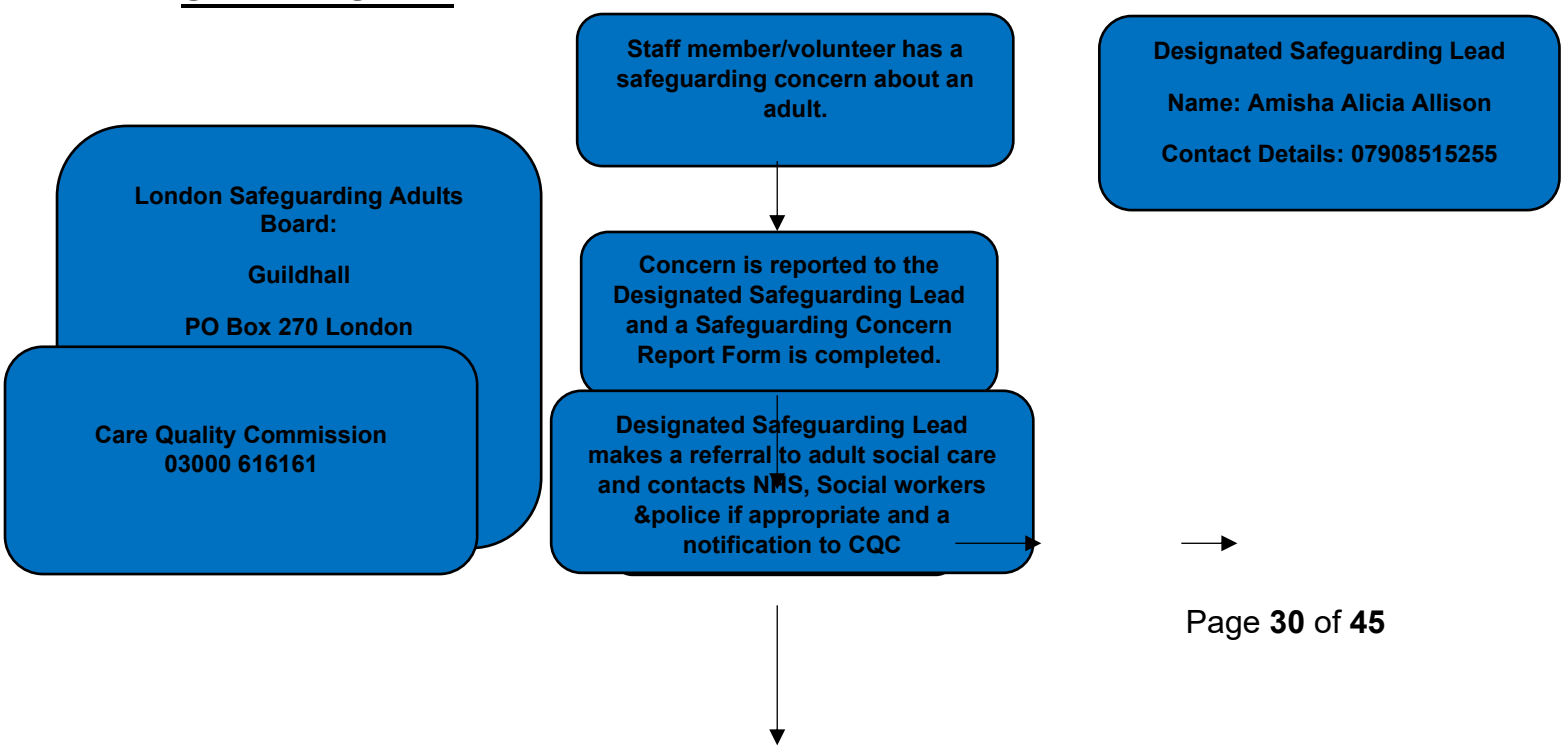
- Stay calm, and listen carefully;
- Assure them that you believe them, and that they will be taken seriously;
- Explain to them that you will have to tell someone, and that it cannot be kept a secret;
- Reassure them that they were right to tell;
- Reassure them that it wasn't their fault;
- Where there is a possibility that forensic evidence may exist, protect the evidence – DO NOT CLEAN UP, or allow them to do so;
- Do not prompt them or ask for more details as this may contaminate evidence and hamper any criminal investigation and / or subsequent prosecution;
- Ascertain the facts – who? what? when? where? how?
- Do not ask leading questions. Use open questions like "anything else to tell me?"
- Make an immediate and accurate record of the allegations made and / or what has been observed, and any action taken;
- Record word-for-word what was said; try not to edit or change the words

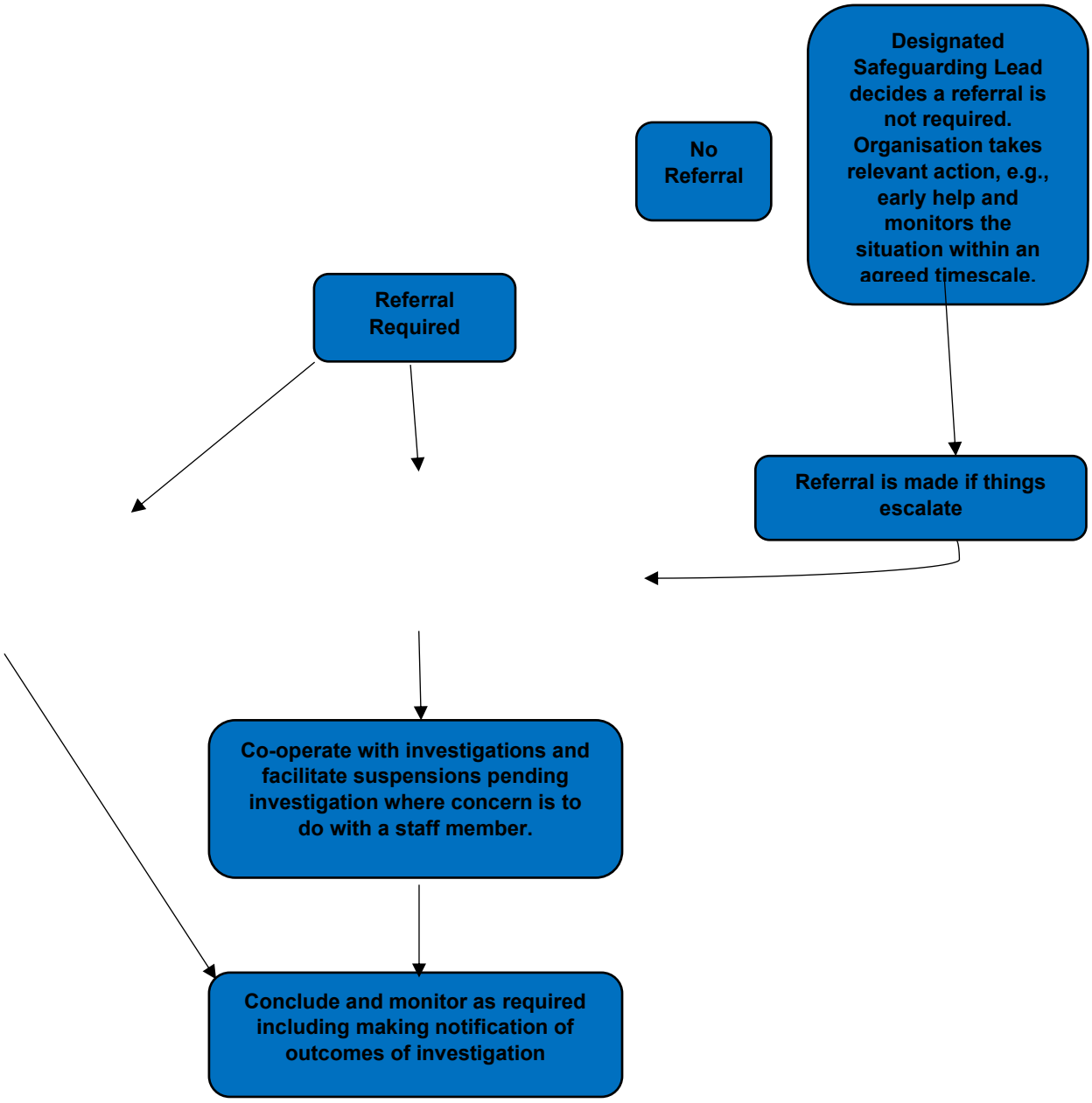
used;

Use a black pen as the document may have to be copied. Sign and date the document as it may have to be copied. Record the location and details of anyone else who was present;

- Submit the report to your manager within 4 hours.
- Detailed information on the reporting process and the handling of an allegation including a process for decision making and responsibilities.

SAFEGUARDING REPORTING FLOW CHART – AA HEALTHCARE SERVICES LTD





NB: We also have a direct external route where the safeguarding is concerned with the safeguarding lead. In these instances, staff may make a direct referral to the local adults safeguarding board as well as contact CQC directly. This constitutes part of the induction and safeguarding training.

ASSURING VULNERABLE SERVICE USERS:

The following essential principles will be upheld during any investigation of a Concern involving a Vulnerable Service user. In summary, a Vulnerable Service user will be assured that:

- Their needs, views and well-being will be central to any investigation or enquiry;
- Their civil and human rights, including the right to Self-Determination, will be upheld during any enquiry; they will have the same rights, and be cared for to access the same services, as all other citizens.
- Any enquiry or investigation, or planning done with them or on their behalf, will be multi-agency, and will access the best possible, and most appropriate resources;
- Responses will be timely and proportionate;
- Information about them will only be shared in accordance with approved and appropriate data-sharing policies;
- There is an established planning and reviewing process, central to which is their safeguarding;
- Any actions needed as a result of the inquiry or investigation will be carried out, and individuals will be held to account for their actions.

Consent and Information Sharing:

There are cases where the service user concerned will refuse their consent for the police or social services to be contacted, for any safeguarding action to be taken, or for their information to be shared with another agency.

The service user has the right to make their own decision and express a wish for concerns not to be pursued. Their wishes should be respected wherever possible, but there are times when their wishes can be overridden.

Consideration will need to be given to other factors such as the seriousness and pervasiveness of the abuse; the ability of the individual to make decisions; the effect of the abuse on the individual in question, and on others; whether a criminal offence has occurred; and whether there is a need for others to know (e.g., to protect others who may not be involved in the immediate situation).

Where this is the case, the service user should be made aware of the risks involved in their decision, be told that they can change their mind at any point and given information about services that could help reduce the risk. Their refusal to consent must also be clearly recorded. If a decision is then made to take the case forward, this must be clearly explained and recorded.

Any member of staff must report suspected abuse to the **AA HEALTHCARE SERVICES LTD** Safeguarding Lead, even if the service user has refused their consent. The Safeguarding Lead will then take the decision whether or not to apply the exceptions below apply.

EXCEPTIONS:

Where a service user is assessed as not having the 'mental capacity' to make this decision, appropriate representatives/advocates should be consulted. However, in such cases it is the final decision of the manager and/or statutory authorities involved.

Where a crime has taken place and there is an overriding public duty for the police to investigate

Where other vulnerable service users may be at harm from the person/group/agency suspected of causing abuse

Where gaining the service user's consent would place them at further risk

Where the service user is at serious risk of harm – this decision should only be taken with multi-agency agreement that this is in the service user's best interests.

Decisions about sharing information must be clearly recorded with reasons clearly stated. Decisions about sharing information must be openly and explicitly discussed at every stage. The General Data Protection Regulation sets out a framework to enable the lawful sharing of information.

Service users have a general right to independence, choice and self-determination including control over information about themselves and their privacy. In the context of service user safeguarding these rights can be overridden in certain circumstances. If the information is confidential, but there is a safeguarding concern, sharing it may

be justified. Refer to the GDPR Data Protection Policy for more information about data and information sharing.

SAFEGUARDING IN COVID ENVIRONMENT

Good practice

AA HEALTHCARE SERVICES LTD complies with the good quality care and practice which are always a good baseline on which to ensure service users are safe, their well-being is promoted and their human rights protected. The crisis meant that there were some easements to the Care Act 2014. These changes temporarily amended some of the duties and powers that local authorities have in relation to providing Care. At the one-year review of the legislation, these easements were expired and will no longer be available through the act.

For the safety of service users, we can best assist them through measures such as Increased social isolation.

AA HEALTHCARE SERVICES LTD acknowledges that isolation with regard to service users living in the community can increase the risk of abuse happening and reduce the likelihood it will be reported and dealt with. These service disruptions may cause the service user to be confused due to changes in routine and to be more socially isolated with fewer daily contacts. The lack of structure and meaningful activity may cause confusion and distress upon them also.

AA HEALTHCARE SERVICES LTD shall try to ensure that the service users we care are able to maintain social contacts as much as possible, within the current guidance.

- Where possible, we will inform Domiciliary Care Service users to keep in touch with friends and family while maintaining social distancing rules.
- We will allow Domiciliary Care Service users to call people they might have seen regularly, or use technology such as WhatsApp or Zoom to maintain contact with family and friends.
- We will encourage visits with family and friends that can safely take place, perhaps through a window or using a screen if people don't yet feel ready to

meet more closely. In the community, we will see if relatives, local volunteers or neighbours can keep an eye on the person while respecting social distancing rules.

STRESS ON INFORMAL CARE GIVERS AND CARING RELATIONSHIPS

There may be additional pressures on informal carers or family members when care such as day services, respite services and lunch clubs have to close. Informal carers and family members may find themselves having to spend longer periods providing care without adequate breaks and assistance. This can cause stress and tensions that put additional strain on the caring relationship.

It is important that informal carers take care of themselves. **AA HEALTHCARE SERVICES LTD** shall help by making sure that they are aware that care is available.

Where we notice a service user is struggling, we will make sure they know they can ask for help from the local authority. If a staff member of **AA HEALTHCARE SERVICES LTD** thinks that the informal carer is not coping and this may cause a risk of abuse or neglect, they must report it to the safeguarding lead officer in line with our safeguarding policy and procedures.

Overstretched and stressed Care staff

AA HEALTHCARE SERVICES LTD acknowledges the implications of COVID-19 on the Care sector which have been well publicised in the media. According to the reports, Staff are facing unprecedented pressures and **AA HEALTHCARE SERVICES LTD** considers the importance in ensuring that they remain cared by employers. Staff wellbeing is important in order to maintain good quality, safe services.

AA HEALTHCARE SERVICES LTD will ensure staff should receive:

- adequate and appropriate personal protective equipment based on risk assessment.
- adequate supervision and care

- appropriate COVID-19 training

AN INCREASE IN CRIMINAL BEHAVIOUR (SCAMS ETC)

Our organisation acknowledges that the pandemic has been seen as an opportunity by some criminals to exploit people with dementia. Financial scams have increased and there has been a noted increase in scams relating to the pandemic, for example, masks ordered online that never arrive, or the offer of false cures. As a front-line worker you are the eyes and ears that may be the first person to pick up any signs of abuse. Here is a checklist of things you can do:

- Talk to our service users about the increased risk of abuse at this time.
- Be aware that any changes in behaviour or demeanour could indicate abuse.
- Advise people not to answer the door to strangers – and be aware of fake ID.
- Try not to alarm service users but ask them to be wary of offers to help, particularly from strangers.
- Advise service users to check with family, friends that offers of care, advice and help are legitimate.
- Warn service users against responding to any text, email or phone call from an unidentified source. Explain that fraudsters will imitate official bodies such as the Government or the NHS – and they do it very well!
- Advise service users that they should never give their personal data, passwords or pin numbers to anyone. Official financial bodies and other organisations will never ask for them.

An increase in domestic abuse

The COVID-19 crisis has caused many people to spend a lot more time with those in their household. In some cases, this has caused additional tensions that spill over into abuse and violence. Those service users who live with an abusive partner or family member may be less likely to ask for help during the pandemic as they may not want

to bother overstretched emergency services. Fewer visitors to the household may mean that evidence of physical abuse goes unnoticed.

Domestic abuse is not just about physical violence. It can include other types of abuse such as emotional or psychological, sexual, financial and neglect. Domestic abuse can be experienced by both men and women. Therefore, our staff and team shall be acquainted to the training regarding to noticing any signs of abuse and if a service user is in immediate danger, they will contact the police. If there are any concerns that abuse is taking place to a service user, our staff shall report it in line with **AA HEALTHCARE SERVICES LTD** safeguarding policy.

A range of new contacts (volunteers, those delivering food and medicines)

The Government has made arrangements for people to be cared for in their homes by volunteers, for example, help with shopping or getting medication, or someone to telephone to make sure they are ok. **AA HEALTHCARE SERVICES LTD** considers this protocol and it shall facilitate for those service users who are considered to be extremely clinically vulnerable to register for care by contacting the Government's helpline on 0800 028 8327. We shall ensure that the service user knows who to tell if they have any concerns and if they have any concerns about the conduct of a staff member, they should raise this to our organisation's safeguarding lead.

ASSOCIATED KEY LINES OF ENQUIRY

SAFE

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Key line of enquiry / prompt

Code

S1 How do systems, processes and practices safeguard people from abuse?

S1.1 How are safeguarding systems, processes and practices developed, implemented and communicated to staff

S1.2 How do systems, processes and practices protect people from abuse, neglect, harassment and breaches of their dignity and respect? How are these monitored and improved?

S1.3 How are people protected from discrimination, which might amount to abuse or cause psychological harm? This includes harassment and discrimination in relation to protected characteristics under the Equality Act.

S1.4 How are people cared for to understand what keeping safe means, and how are they encouraged and empowered to raise any concerns they may have about this? If people are subject to safeguarding enquiries or an investigation, are they offered an advocate if appropriate or required?

S.2 **How are risks to people assessed and their safety monitored and managed so they are cared for to stay safe and their freedom is respected?**

S2.1 What arrangements are there to manage risks appropriately, and to make sure that people are involved in decisions about any risks they may take?

S2.2 How do risk management policies and procedures minimise restrictions on people's freedom, choice and control, in particular for people who lack mental capacity?

S2.3 Are people's records accurate, complete, legible, up-to-date, securely stored and available to relevant staff so that they care people to stay safe?

S2.4 Are formal and informal methods used to share information with appropriate parties on risks to people's care, treatment and care?

S2.5 Are there thorough, questioning and objective investigations into whistleblowing or staff concerns, safeguarding, and accidents or incidents? Are action plans developed, and are they monitored to make sure they are delivered?

S2.6 How is equipment, which is owned or used by the provider, managed to care people to stay safe? How are the premises and safety of communal and personal spaces (such as bedrooms) and the living environment checked and managed to care people to stay safe? How does the provider manage risks where they provide care in premises, they are not responsible for?

S2.7 How do staff seek to understand, prevent and manage behaviour that the service finds challenging? How are individuals cared when their behaviour challenges? How well does this align with best practice?

S3 How does the service make sure that there are sufficient numbers of suitable staff to care for people to stay safe and meet their needs?

S3.1 What arrangements are there, including within the rotas, for making sure that staff have the right mix of skills, competencies, qualifications, experience and knowledge, to meet people's individual needs?

S3.2 How is safety promoted in recruitment practices, arrangements to care staff, training arrangements, disciplinary procedures, and ongoing checks?

S3.3 Do staff receive effective training in safety systems, processes and practices?

S4 How does the provider ensure the proper and safe use of medicines?

S4.1 Is the service's role in relation to medicines clearly defined and described in relevant policies, procedures and training? Is current and relevant professional guidance about the management of medicines followed?

S4.2 How does the service make sure that people receive their medicines (both prescribed and non-prescribed) as intended (including controlled drugs and 'as required' medicines), and that this is recorded appropriately?

S4.3 How are medicines ordered, transported, stored, and disposed of safely and securely in ways that meet current and relevant legislation and guidance?

S4.4 Are there clear procedures for giving medicines covertly, in line with the Mental Capacity Act 2005?

How does the service make sure that people's behaviour is not controlled by excessive or inappropriate use of medicines?

S4.5 How does the service make sure that people's behaviour is not controlled by excessive or inappropriate use of medicines?

S4.6 How do staff assess the level of care a person needs to take their medicines safely, particularly where there are difficulties in communicating, when medicines are being administered covertly, and when undertaking risk enablement assessments designed to promote self-administration?

S4.7 How does the service engage with healthcare professionals in relation to reviews of medicines at appropriate intervals?

S4.8 How do staff make sure that accurate, up-to-date information about people's medicines is available when people move between care settings? How do medicines remain available to people when they do so?

S5 How well are people protected by the prevention and control of infection?

S5.1 What are the arrangements for making sure that premises are kept clean and hygienic so that people are protected from infections that could affect both staff and people using services?

S5.2 Do staff understand their roles and responsibilities in relation to infection control and hygiene?

S5.3 Are policies and procedures maintained and followed in line with current relevant national guidance?

S5.4 Where it is part of the service's role to respond to and help to manage infections, how does the service make sure that it alerts the right external agencies to concerns that affect people's health and wellbeing?

S5.5 Have all relevant staff completed food hygiene training and are correct procedures in place and followed wherever food is prepared and stored?

S6 Are lessons learned and improvements made when things go wrong?

S6.1 Do staff understand their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally, where appropriate?

S6.2 What are the arrangements for reviewing and investigating safety and safeguarding incidents and events when things go wrong? Are all relevant staff, services, partner organisations and people who use services involved in reviews and investigations?

S6.3 How are lessons learned and themes identified, and is action taken as a result of reviews and investigations when things go wrong?

S6.4 How well is the learning from lessons shared to make sure that action is taken to improve safety across relevant parts of the service? Do staff learn from reviews and investigations by other services and organisations?

S6.5 How effective are the arrangements to respond to relevant external safety alerts, recalls, inquiries, investigations or reviews?

ASSOCIATED LEGISLATION

- The Care Act 2014
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015
- Children Act 1989
- Children Act 2004
- Children and Young Persons Act 1933
- Equality Act 2010
- Equality Act 2010: Chapter 1 (protected characteristics) Chapter 2 (prohibited conduct) and Chapter 3 (services and public functions)
- Human Rights Act 1998
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice
- Mental Health Act 1983
- Mental Health Act 2007 and Code of Practice
- Protection of Freedoms Act 2012 – links to The Protection of Freedoms Act 2012(Disclosure and Barring Service Transfer of Functions) Order 2012
- Safeguarding Vulnerable Groups Act 2006

FURTHER GUIDANCE

Care Act and Care Certificate

Care Act 2014 (Social Care Institute for Excellence)

Care Act 2014 part 1: factsheets (Department of Health, June 2014)

Care and care statutory guidance, issued under the Care Act 2014 (Department of Health, March 2016)

Challenging behaviour

Services for people with learning disabilities and challenging behaviour or mental health needs – Mansell report: revised edition (Department of Health)

Data protection

Information sharing: Guidance for practitioners and managers – departmental advice for professionals on when and how to share information about children, young people and families (HM Government)

Dignity and respect

Dignity in Care – SCIE guide 15 (Social Care Institute for Excellence, June 2010 (updated May 2013))

Equality and human rights

Equality Act 2010 guidance

Guidance for service providers about their duties under the Equality Act 2010 (Equality and Human Rights Commission)

Services, public functions and associations: Statutory Code of Practice (Equality and Human Rights Commission)

General resource

National Institute for Health and Care Excellence (NICE)

Mental capacity

Mental Capacity Act 2005 Code of Practice

Mental health

Code of Practice: Mental Health Act 1983 (Department of Health)

Quality monitoring/governance

National Institute for Health and Care Excellence (NICE) guidance

National Institute for Health and Care Excellence (NICE) quality standards topic library

Restrictive practice/restraint

Positive and proactive care: reducing the need for restrictive interventions (Department of Health)

Risk assessment

Health and Safety Executive, Sensible risk assessment in care settings

Risk assessment (Health and Safety Executive)

Safeguarding

Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children (Department for Education)

What to do if you're worried a child is being abused (HM Government)

When to suspect child maltreatment - NICE guideline CG89 (National Institute for Health and Care Excellence, June 2009)

Whistleblowing

Raising a concern with CQC: A quick guide for health and care staff about whistleblowing (Care Quality Commission)

Raising concerns at work: whistleblowing guidance for workers and employers in health and social care

Whistleblowing: Guidance for providers who are registered with the Care Quality Commission (Care Quality Commission, November 2013)

Review

Reviewed and checked by:	Amisha Alicia Allison
Review date:	25/05/2025
To be reviewed on:	24/05/2026