NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Safeguarding adults in care homes

Draft for consultation, September 2020

This guideline covers keeping adults in care homes safe from abuse and neglect. It includes potential indicators of abuse and neglect (by individuals and by organisations), and covers the safeguarding process from identifying a concern through to conducting a safeguarding enquiry. There are recommendations on policy, training and care home culture, to help care homes improve staff awareness of safeguarding and ensure they are willing and able to report concerns when needed.

Who is it for?

- Care home providers, managers, staff and volunteers
- Other health and social care practitioners working with adults in care homes
- Health and social care commissioners of residential care for adults
- Local authorities and Safeguarding Adults Boards
- Adults living in care homes, their families, friends, carers and advocates, and the public.

What does it include?

This draft guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice.

- the guideline context.

Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

The recommendations in this guideline were developed before the COVID-19 pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication.

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Contents

Context

According to the Care Quality Commission's state of care report for 2018/19, there are over 11,300 residential care homes and 4,400 nursing homes in the UK. These provide support to around 410,000 older people (as estimated by the 2017 Competition and Markets Authority care homes market study). As well as long-term residents, residential and nursing homes provide services for people who stay for shorter periods, including as day visitors. This is sometimes referred to as respite care or short break services. Many of these long- and short-term residents have high care and support needs, and this means they are at an increased risk of abuse and neglect.

The quality of care in many care homes is good, but this is not always the case. The Care Quality Commission's 2019 report rated homes as follows:

- inadequate: 2% of nursing homes and 1% of care homes
- requiring improvement: 22% of nursing homes and 14% of care homes
- good: 72% of nursing homes and 82% of care homes
- outstanding: 4% of nursing homes and 3% of care homes.

The need for the guideline

All adult safeguarding, including safeguarding in care homes, should be underpinned by the Care Act 2014, the Care Act 2014 statutory guidance, and the Making Safeguarding Personal framework.

Despite the legal framework and the associated guidance, safeguarding procedures and practice vary at the local level. In particular, care homes often struggle to understand:

- the difference between safeguarding issues and poor practice
- when and how to make safeguarding referrals to the local authority.

The Safeguarding Adults 2019 Annual Report reported that care homes (including homes with and without nursing) accounted for 34% of all safeguarding enquiries conducted under section 42 of the Care Act 2014.

The purpose of this guideline

This guideline makes action-orientated recommendations to improve safeguarding for residents of care homes. It covers all adult residents of care homes, including people who stay at care homes for shorter periods (for example day visitors).

The guideline is based on:

- the best available evidence on effectiveness (including cost effectiveness)
- evidence on the views and experiences of care home residents, their families and carers, and practitioners involved in care and support for residents.

The guideline is also informed by existing adult safeguarding guidance from across these different sectors, including:

- Association of Directors of Adult Social Services, Local Government Association (2019) Making decisions on the duty to carry out Safeguarding Adults enquiries.
- Association of Directors of Adult Social Services, Social Care Institute for Excellence, National Health Service London, Metropolitan Police (2019) London multi-agency adult safeguarding policy and procedures.
- Association of Directors of Adult Social Services North East (2011) Safeguarding threshold guidance
- Department of Health, Social Services and Public Safety (2009) Adult abuse: recognising adult abuse and what to do about it! Guidance for staff
- Royal College of Nursing (2018) Adult safeguarding: roles and competencies for healthcare staff.
- Skills for Care (2017) What do I need to know about safeguarding adults?
- Social Care Institute for Excellence (2018) Adult safeguarding practice questions
- Social Care Institute for Excellence (2015) At a glance 69: Safeguarding adults: Types and indicators of abuse
- Social Care Wales (2019) The social care manager: practice guidance for social care managers registered with Social Care Wales.
- Volunteer Now (2010) Safeguarding vulnerable adults: a shared responsibility

How it relates to legislation, statutory guidance and other NICE guidelines

The core legal duty for adult safeguarding is found in section 42 of the Care Act 2014. This places a statutory duty on local authorities to conduct an enquiry when there is reasonable cause to suspect that an adult with care and support needs:

- is experiencing or at risk of abuse or neglect **and**
- as a result of their needs is unable to protect themselves.

The local authority is the lead agency for adult safeguarding and should be notified whenever abuse or neglect is suspected. They will decide whether a safeguarding enquiry is necessary, and if so who will conduct it. The decision to conduct an enquiry depends on the criteria set out above, and not on whether a person is eligible for or receiving services funded by the local authority.

Any actions taken in relation to a safeguarding concern should be based on the 6 principles set out in the Care Act statutory guidance. These principles should be known and understood by everyone working in care homes and should be part of their everyday practice:

1. **Empowerment:** People being supported and encouraged to make their own decisions and informed consent.

2. **Prevention:** It is better to take action before harm occurs.

3. **Proportionality:** The least intrusive response appropriate to the risk presented.

4. **Protection:** Support and representation for those in greatest need

5. **Partnerships:** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

6. **Accountability:** Accountability and transparency in delivering safeguarding.

As well as the 6 principles, this guideline also recognises the importance of the wellbeing principle within the Care Act, and the safeguarding approaches based on

the Making Safeguarding Personal framework. These both emphasise that people who have experienced or are at risk of abuse or neglect should be meaningfully involved in safeguarding whenever possible. Outcomes should be meaningful to the person, rather than simply following a process.

This approach is also endorsed by the Care Act statutory guidance, which states that:

> '… safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances.'

The guideline complements statutory duties and good practice as set out in relevant legislation and guidance. The recommendations cross-refer to legislation and other guidance where appropriate. In particular, the guideline takes account of the Care Act 2014 and the Care Act 2014 statutory guidance, the Mental Health Acts 1983 and 2007, and the Health and Social Care Act 2008. It is also underpinned by the Human Rights Act 1998, notably Article 3 (No one shall be subjected to torture or to inhuman or degrading treatment or punishment) and Article 5 (Right to liberty and security).

Also, because many people who use care homes may lack the capacity to make certain decisions, this guidance is also informed by the Mental Capacity Act 2005 and the Mental Capacity (Amendment) Act 2019. When a care home resident lacks capacity, this guideline should be used in line with the NICE guideline on decision making and mental capacity.

NICE guidelines provide recommendations on what works. This may include details on who should carry out interventions and where. NICE guidelines do not routinely describe how services are funded or commissioned, unless this has been formally requested by the Department of Health and Social Care.

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Policy and procedure

Care home safeguarding policy and procedure

1.1.1 Care homes and care home providers must have a safeguarding policy and procedure in place, to meet the requirements of the Care Act 2014, the Care Act 2014 statutory guidance. This policy should be in line with local safeguarding arrangements and the arrangements made by their local Safeguarding Adults Board.

1.1.2 Care home and care home provider safeguarding policies should:

- be clearly written and in line with accessibility requirements
- be easy to find, so that all residents, staff, visitors and service providers can read it when they need to
- include clear and transparent arrangements for identifying, responding to and managing safeguarding concerns, and involve residents (and their families and carers) in designing and reviewing these arrangements
- explain how to respond to safeguarding concerns, and how to report suspected abuse or neglect
- be based on the principle of collaborative working (because safeguarding is everyone's responsibility).

1.1.3 Care homes and care home providers should have systems in place to track and monitor incidents, accidents, disciplinary action, complaints and safeguarding concerns, to identify patterns of potential harm.

1.1.4 Care homes should have systems in place for preserving evidence from reported safeguarding concerns, including care records, as these may be required in future (for example for police investigations).

1.1.5 Care homes should have a process for recording and sharing information (in line with current data protection laws) about safeguarding concerns.

For a short explanation of why the committee made the 2020 recommendations on safeguarding policy and procedure and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in:

- evidence review B: barriers and facilitators to identifying abuse and neglect
- evidence review D: responding to and managing safeguarding concerns in care homes
- evidence review C: tools to support recognition and reporting of safeguarding concerns.

Care home whistleblowing policy and procedure

1.1.6 Care homes and care home providers should have a whistleblowing policy and procedure, and make sure that staff are aware of these.

1.1.7 Care home providers should consider using an external whistleblowing service (for example through arrangements with another provider). If they do, they should make sure that staff know how to contact the service.

1.1.8 Be aware that whistleblowers (including residents) are protected by law. Care homes and care home providers must ensure that whistleblowers are not victimised as a result of reporting or disclosing a safeguarding concern.

1.1.9 Be aware that care home staff and residents (and their families and carers) may be afraid of the repercussions of whistleblowing, and this can prevent them from identifying and reporting abuse and neglect.

For a short explanation of why the committee made the 2020 recommendations on whistleblowing policy and procedure and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review C: tools to support recognition and reporting of safeguarding concerns.

Care home and care home provider roles and responsibilities

1.1.10 Care homes and care home providers should:

- have a safeguarding lead **and**
- make sure everyone knows who this is, what they do, how to contact them, and who to speak to if they are unavailable.

1.1.11 Care homes and care home providers should make it clear who is accountable, in addition to the safeguarding lead, for different aspects of safeguarding work within each care home.

1.1.12 All care home job descriptions (including at board level) should set out the safeguarding responsibilities included as part of that role.

1.1.13 Care homes and care home providers should ensure that all staff understand how to meet their safeguarding responsibilities in their day-to-day work within the care home.

1.1.14 Care homes should regularly audit care records and ensure that they are complete and available, in case they are needed if a safeguarding concern is raised.

For a short explanation of why the committee made the 2020 recommendations on roles and responsibilities and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review F: barriers and facilitators to effective strategic partnership working.

Local authorities, clinical commissioning groups, and other commissioners

1.1.15 Local authorities and other commissioners should ensure that all care homes they work with are fulfilling their statutory and contractual safeguarding responsibilities. This includes organising quality checks of care homes.

1.1.16 Commissioners should contribute to improving safeguarding practice in the care homes they work with, including helping care homes to learn from experience in commissioning, care home management and Safeguarding Adults Reviews.

1.1.17 Commissioners should:

- ensure that care homes are maintaining records about safeguarding
- make record-keeping responsibilities clear as part of contract management.

For a short explanation of why the committee made the 2020 recommendations for local authorities and other commissioners and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review F: barriers and facilitators to effective strategic partnership working.

Safeguarding Adults Boards

1.1.18 Safeguarding Adults Boards should ensure that they know who the safeguarding leads are in care homes and care home providers, and how to contact them. They should ensure that safeguarding leads are clear about how to contact the Board.

1.1.19 Safeguarding Adults Boards and sub-groups to the Board should engage with care homes (including care home providers, staff, residents and their families and carers), to ensure that the Board's recommendations for them are useful and appropriate.

1.1.20 Safeguarding Adults Boards should ensure that partner organisations are working together to support residents during safeguarding enquiries.

1.1.21 Safeguarding Adults Boards should invite care homes to contribute to the Board's annual report, highlighting achievements, opportunities and challenges in relation to safeguarding.

1.1.22 Safeguarding Adults Boards should establish escalation procedures to resolve any safeguarding disputes with care homes.

For a short explanation of why the committee made the 2020 recommendations for Safeguarding Adults Boards and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting and evidence review F: barriers and facilitators to effective strategic partnership working.

1.2 Induction and training in care homes

1.2.1 All staff working in care homes should read and understand the safeguarding policy and procedure.

1.2.2 All staff working in care homes should have mandatory training on safeguarding during their induction.

1.2.3 Care homes should ensure that all staff (including contract or temporary staff):

- attend mandatory training on safeguarding as soon as possible, and no later than 6 weeks after they start, **and**
- refresh this knowledge annually.

1.2.4 Safeguarding Adults Boards should:

- consider organising mandatory safeguarding training for staff on a multi-agency basis, working together with related service providers and other health and social care organisations
- tailor this training to reflect the safeguarding responsibilities of each member of staff (so staff with more responsibilities receive more comprehensive training).

1.2.5 Care homes should give staff protected time for induction and mandatory safeguarding training. They should ensure that staff have enough time to read and understand the induction and training materials and improve their knowledge and confidence about safeguarding.

1.2.6 Care homes should:

- assess staff understanding of safeguarding before and after induction and mandatory safeguarding training, to identify any changes and areas for improvement
- request feedback on training methods
- help staff to understand the indicators of abuse and neglect, so they can identify these safeguarding concerns more accurately
- help staff increase their confidence in managing safeguarding concerns.

For a short explanation of why the committee made the 2020 recommendations on induction and mandatory training and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in:

- evidence review B: barriers and facilitators to identifying abuse and neglect
- evidence review H: the effectiveness and acceptability of safeguarding training
- evidence review I: embedding organisational learning about safeguarding.

What mandatory training should cover

1.2.7 At a minimum, mandatory safeguarding training should cover:

- safeguarding and legal principles under the Care Act 2014
- the 6 core principles of safeguarding and the Making Safeguarding Personal framework
- specific responsibilities and accountabilities for safeguarding in the care home
- how to recognise different forms of abuse and neglect, including organisational abuse and neglect
- how to recognise the differences between poor practice and abuse and neglect
- the care homes whistleblowing policy and procedure, including what support and information is available in this situation
- how to act on and report suspected abuse or neglect
- how to raise safeguarding concerns within the care home, and with local authorities and through multi-agency reporting
- how to escalate concerns (for example, to appropriate helplines or the Care Quality Commission) if staff feel that the response taken was not appropriate or effective, or if the concern relates to the actions of the care home manager
- how to talk about and share information about safeguarding with residents, their families and carers
- confidentiality and data protection
- the duty of candour, and being open and honest when things go wrong
- duties under the Public Interest Disclosure Act 1998

- other training that is needed, based on the staff member's role and their specific safeguarding responsibilities.

1.2.8 Mandatory safeguarding training should include reflective learning at the individual, team and organisational level and include opportunities for problem-solving.

1.2.9 Mandatory safeguarding training should include an explanation of safeguarding terminology, including translations if needed, for staff who speak English as a second language.

For a short explanation of why the committee made the 2020 recommendations on what mandatory training should cover and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in

- evidence review B: barriers and facilitators to identifying abuse and neglect
- evidence review H: the effectiveness and acceptability of safeguarding training
- evidence review I: embedding organisational learning about safeguarding.

Further training

1.2.10 Further training could cover:

- how to ask about abuse and neglect in a sensitive and non-judgemental manner
- how frequently to assess and ask about abuse and neglect
- the wide range of situations and circumstances in which abuse and neglect can potentially occur
- less obvious indicators of abuse and neglect, and more complex safeguarding concerns (for example organisational abuse and neglect)
- risk assessments and their relationship to safeguarding
- the skills needed to support a resident through a safeguarding enquiry.

For a short explanation of why the committee made the 2020 recommendations on continuing training and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting and evidence review H: the effectiveness and acceptability of safeguarding training.

How to conduct training

1.2.11 Provide mandatory safeguarding training face-to-face whenever possible. This can be delivered either in person or via virtual platforms. It should be live and interactive and e-learning should only be used when face-to-face training is not possible.

1.2.12 Include case studies and reflective practice when training and learning at the team and organisational level (for example, at team meetings and handovers).

1.2.13 Use case studies and examples to teach staff how safeguarding relates to personalised care and the human rights of residents.

1.2.14 Incorporate recommendations and other information from Safeguarding Adults Reviews into training as quickly as possible after the reports publish.

1.2.15 Training should be directly applicable to the responsibilities and daily practices of the person being trained, and to the care and support needs of the residents they are working with.

1.2.16 If using e-learning, be aware of the limitations, for example, the lack of opportunity for discussion and asking questions, and the difficulty in ensuring that people have understood the training.

1.2.17 If using e-learning, care home managers should assess staff literacy levels and IT skills to ensure the training is appropriate. If staff cannot

use it, find an alternative e-learning programme or another way to conduct training.

For a short explanation of why the committee made the 2020 recommendations on how to conduct training and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review H: the effectiveness and acceptability of safeguarding training.

Evaluating training

1.2.18 Care home managers should ensure that staff are learning from training and using it to improve their practice. This could be checked by:

- random quality-checking and sampling
- follow-up conversations with staff
- ensuring that training is completed on-site and within a specific timeframe.

1.2.19 Care home managers should evaluate changes in understanding and confidence before and after training. Assess this:

- immediately after the training
- annually
- in regular long-term evaluations (for example, as part of supervision sessions).

1.2.20 Line managers should provide positive feedback to encourage staff to complete and learn from their training, for example, during staff appraisals. This could include recognising and acknowledging new skills and competences, and changes in attitudes and behaviours.

For a short explanation of why the committee made the 2020 recommendations on evaluating training and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review H: the effectiveness and acceptability of safeguarding training and evidence review I: embedding organisational learning about safeguarding.

1.3 Care home culture, learning and management

Management skills and competence

1.3.1 Registered managers and providers of regulated care must comply with all safeguarding requirements in regulations 12 and 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

1.3.2 Care home managers and safeguarding leads should lead by example in maintaining up-to-date knowledge on safeguarding.

For a short explanation of why the committee made the 2020 recommendations on management skills and competence and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning about safeguarding.

Line management and supervision

1.3.3 Be aware that staff may be reluctant to challenge poor practice or raise concerns about potential abuse or neglect, particularly if they feel isolated or unsupported.

1.3.4 Care home managers and supervisors should promote reflective supervision to help staff understand how to identify and respond to potential abuse and neglect in care homes. Consider making this independent of line management.

1.3.5 Line managers should provide positive feedback (through supervision and appraisals) acknowledging how staff have learned from their experience of identifying, reporting and managing safeguarding concerns.

1.3.6 Care home managers should encourage staff to discuss care home culture, learning and management in relation to safeguarding in exit interviews when leaving employment with the care home.

1.3.7 Be aware of the potential for under-reporting of safeguarding concerns by staff who may be afraid of losing their job (for example staff who have their housing or work permit linked specifically to their current role).

For a short explanation of why the committee made the 2020 recommendations on line management and supervision and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review I: embedding organisational learning about safeguarding.

Care home culture

1.3.8 Care home providers (including trustees and company directors) and managers should:

- promote a culture in which safeguarding is openly discussed and abuse and neglect can be readily reported
- ensure that support is readily available for people raising concerns (for example, by appointing safeguarding champions).

1.3.9 Staff should be encouraged to watch out for changes in the mood and behaviour of residents, because this might indicate abuse or neglect (see indicators of individual abuse and neglect).

1.3.10 Staff should record and share relevant and important information in a timely manner (for example, at every shift handover or transfer of care), for the benefit and safety of residents.

1.3.11 Care home managers should make sure there are regular opportunities for all staff to:

- share best practice in safeguarding, including learning from Safeguarding Adults Reviews
- challenge poor practice or discuss uncertainty around practice
- discuss the differences between poor practice (which is not necessarily a safeguarding issue) and abuse or neglect (which are safeguarding issues).

Care home managers should make particular efforts to involve staff who work alone or who get very little supervision in these opportunities for learning.

1.3.12 Care home managers should ask for feedback about safeguarding from residents (and their families, friends and carers) and other people working in care homes. They should:

- ask them about their experience of safeguarding concerns and how these have been identified, reported, managed and resolved
- respond to feedback and tell people about any changes made in response to their comments.

This could be done using surveys, meetings and where appropriate, other community engagement (such as open days and visits).

For a short explanation of why the committee made the 2020 recommendations on care home culture and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review I: embedding organisational learning about safeguarding.

Multi-agency working and shared learning with other organisations

1.3.13 Care homes should work with the local authority, Clinical Commissioning Groups and other local agencies to establish a local strategic partnership agreement about safeguarding adults in care homes that covers:

- information sharing and communication protocols

- roles, responsibilities and accountability for safeguarding within each organisation
- procedures for raising and managing a safeguarding concern, the decision-making process and the procedure for enquiries
- definitions of good practice and poor practice
- the indicators of abuse and neglect that should result in safeguarding action (based on the indicators in sections 1.4 and 1.5 of this guideline).

1.3.14 Local health, social care and other practitioners working with care homes should use a multi-agency approach to safeguarding, bringing together a wide range of skills and expertise to keep residents safe.

1.3.15 Safeguarding Adults Boards should arrange opportunities for staff and residents to learn together from recent experiences of safeguarding.

1.3.16 Care home managers and providers should be aware that some staff may be apprehensive about external oversight, and may need time to build relationships with external agencies before effective learning can take place.

1.3.17 Care home managers and providers should share their experiences of managing safeguarding concerns with Safeguarding Adults Boards, so that other care homes and providers can learn from this.

1.3.18 Care home managers and providers should share relevant information from Safeguarding Adults Board meeting minutes and reports with their staff.

For a short explanation of why the committee made the 2020 recommendations on multi-agency working and learning with other organisations, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in:

- evidence review D: responding to and managing safeguarding concerns in care homes and evidence review
- evidence review F: strategic partnership working
- evidence review I: embedding organisational learning about safeguarding.

Record-keeping

1.3.19 Care home managers should ensure that actions taken to safeguard residents are recorded, and shared with other staff.

1.3.20 Care home managers should ensure that all records are focused on the wellbeing of the individual resident. Records should be clear and easily accessible for purposes such as performance management, audits, court proceedings, Care Quality Commission inspections, or learning and development.

1.3.21 Care home managers should regularly review records for accuracy, quality and appropriateness.

For a short explanation of why the committee made the 2020 recommendations on record-keeping and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning about safeguarding.

1.4 Indicators of individual abuse and neglect

This section describes indicators that should alert people to the possibility of abuse or neglect of individuals within a care home.

The terms 'consider' and 'suspect' are used to define the extent to which an indicator suggests abuse or neglect, with 'suspect' indicating a stronger likelihood of abuse or neglect.

- To 'consider' abuse or neglect means that this is one possible explanation for the indicator.
- To 'suspect' abuse or neglect means a serious level of concern about the possibility of abuse or neglect.

None of the indicators are proof of abuse or neglect on their own. Instead, they are signs that the pathway set out in this guideline should be followed.

If a resident is in immediate danger go straight to immediate actions to take if you suspect abuse or neglect. Otherwise, follow the steps below if you discover any of the indicators listed. This process is in line with the Department of Health and Social Care statutory guidance on adult safeguarding.

Some behavioural and emotional indicators of abuse and neglect may be due to non-recent incidents or experiences, including childhood abuse or past experience of domestic violence.

Some indicators of abuse and neglect can be similar to behaviours arising from other causes. In particular, there can be similarities with behaviours that may be associated with dementia, autism, learning disability or acute mental distress. However, the possibility of abuse or neglect should always be considered as a cause of behavioural and emotional indicators, even if they are seemingly explained by something else. This is particularly important for residents who do not communicate using speech.

Physical, sexual, psychological and financial abuse may be perpetrated by volunteers, visitors, and family members and carers, as well as by care home staff. In some cases, this can be a continuation of past relationships of domestic violence or abuse.

1.4.1 Health and social care practitioners should provide information to residents and their families and carers, covering what abuse and neglect look like and how to recognise warning signs.

1.4.2 If the indicators relate to a past incidence of abuse or neglect, and the resident is currently in a safe environment, someone who has a positive relationship with the resident should find out what support (if any) they would like.

1.4.3 When responding to all indicators of abuse and neglect:

- follow the principles of the Making Safeguarding Personal framework

- ensure that any actions are guided by the wishes and feelings of the resident
- for guidance on capacity, see the NICE guideline on decision-making and mental capacity.

1.4.4 If a resident does not want any safeguarding actions to be taken, but abuse or neglect is suspected then follow the recommendations in this guideline from section 1.5 onwards. Note that referral to the local authority must be made if there is a perceived risk to other residents, even where the resident does not want this.

Neglect

1.4.5 Consider neglect when residents:

- are not supported to present themselves the way they would like (for example, haircuts, makeup, fingernails and oral hygiene)
- occasionally have poor personal hygiene or are wearing dirty clothes
- are wearing clothing that is unsuitable for the temperature or the environment
- have lost or gained weight unintentionally
- do not have access to food and drink in line with their dietary needs
- have repeated urinary tract infections
- are not getting care to protect their skin integrity, potentially leading to pressure ulcers (see the NICE guideline on pressure ulcers, and the quick guide on preventing pressure ulcers in care homes)
- do not have opportunities to spend time with other people, either virtually or in person
- uncharacteristically refuse or are reluctant to engage in social interaction
- do not have opportunities to do activities that are meaningful to them
- do not have access to medical and dental care
- have not received prescribed medication, or medication has been administered incorrectly (for example, the wrong dose, timing, method, or type of medication).

- do not have access to outdoor space, fresh air and sunlight
- are not given first aid when needed.

1.4.6 Suspect neglect when residents:

- do not have an agreed care and support plan
- are not receiving the care in their agreed care and support plan
- have deteriorating physical or mental health, and there is a lack of response to this from staff
- live in a dirty, unhygienic or smelly environment
- repeatedly have poor personal hygiene or are wearing soiled or dirty clothes
- are malnourished
- frequently and uncharacteristically do not engage with other people
- have only inconsistent or reluctant contact with external health and social care organisations
- have restricted access to food or drink, if this is not part of their agreed care and support plan
- are not kept safe from everyday hazards or dangerous situations
- repeatedly do not receive prescribed medication, or medication has been repeatedly administered incorrectly (for example the dose, timing, method, or type of medication).
- are denied independence aids (such as hearing aids, glasses or dentures), contrary to their care and support plan.

1.4.7 Be aware that some indicators of neglect may result from self-neglect. When deciding whether to intervene because of self-neglect:

- think about why the resident may be refusing support
- think about whether the resident has capacity to understand the possible impact of their self-neglect on themselves and others (see the NICE guideline on decision-making and mental capacity)
- if the resident is refusing support, ask them why, and ask if they would like a different kind of support

- make an assessment based on the risks and needs specific to the resident, in line with the Care Act 2014 statutory guidance.

Physical abuse

1.4.8 Consider physical abuse when residents:

- have unexplained marks or injuries (for example minor bruising, cuts, abrasions or reddened skin)
- tell you or show signs that they are in pain, and the cause is unexplained (for example, the pain is not caused by a pre-existing medical condition).

1.4.9 Suspect physical abuse when residents:

- have multiple or repeated marks or injuries (for example, bruising, cuts, lesions, loss of hair in clumps, bald patches, burns and scalds)
- have injuries that are very unlikely to be accidental (for example grip marks, cigarette burns or strangulation marks)
- are being restrained without authorisation (either by direct restraint or by being confined to a particular area)
- flinch when approached, or change their behaviour (for example, acting subdued) in the presence of a particular person
- have fractures that cannot be explained
- have their activity limited by misuse of medication, or covert administration when not medically authorised.

1.4.10 Act immediately to safeguard residents and contact the police if you witness an assault or are told that a resident has been assaulted (see making sure people are safe).

1.4.11 Be aware that injuries can be caused by other residents.

Sexual abuse

1.4.12 Consider sexual abuse when residents:

- are spoken to or referred to using sexualised language

- experience any instances of sexualised behaviour or teasing
- change their behaviour, for example:
  - resisting being touched
  - becoming aggressive or withdrawn
  - having trouble sleeping
  - using sexualised language
  - showing highly sexualised behaviours
- show changes in their relationships (for example, being afraid of or avoiding particular residents, family members or members of staff).

1.4.13 Suspect sexual abuse when residents:

- report being inappropriately touched or experience unwanted sexualised behaviours
- have unexplainable physical symptoms that may be associated with sexual activity, such as itching, bleeding or bruising to the genitals, anal area or inner thighs
- have unexplained bodily fluids on their underwear, clothing or bedding
- are involved in a sexual act with another person and consent is unclear
- have a sexually transmitted infection
- have an intimate relationship with a member of staff
- have a sexual relationship with a family member other than husband, wife or partner
- have a sexual relationship with another resident, if capacity is unclear for either person
- become pregnant.

Psychological abuse

1.4.14 Consider psychological abuse when residents:

- are addressed rudely or inappropriately on any occasion (verbally or non-verbally)
- are prevented from speaking freely

- are deliberately and systematically isolated by other residents and/or staff
- have information about their own care systematically withheld from them by the care home
- are not involved in planning their own care, or when changes are made to their care without discussion or agreement
- are denied a choice on any occasion (for example, around activities of daily living or freedom of movement)
- are denied unsupervised access to others
- show significant and otherwise unexplainable changes in their behaviour, including:
  - becoming withdrawn
  - avoiding or being afraid of particular individuals
  - being too eager to do anything they are asked
  - compulsive behaviour
  - not being able to do things they used to be able to do
  - not being able to concentrate or focus.

1.4.15 Suspect psychological abuse when residents:

- are repeatedly addressed rudely or inappropriately (verbally or non-verbally)
- are shouted at or verbally threatened
- are repeatedly humiliated, belittled, or have their opinions or beliefs undermined
- are getting married or entering a civil partnership, if they do not have capacity to consent to do this.
- are denied access to independent advocacy
- are repeatedly denied choices (for example, around their activities of daily living or freedom of movement).

Financial and material abuse

1.4.16 Be aware that not having systems to take care of residents money and possessions is a form of organisational abuse and can lead to financial abuse.

1.4.17 Consider financial and material abuse when residents:

- do not have their money or possessions appropriately recorded by the care home
- lose money or possessions
- do not have access to their money, or to possessions that they want or need
- are not routinely involved in decisions about how their money is spent or how their possessions are used
- appear to have bought things they do not need or invested money in things when they may lack capacity to make informed decisions
- find the person managing their financial affairs to be evasive or uncooperative
- family or others show unusual interest in their assets
- have unusual difficulty with their finances, and are uncharacteristically protective of money and things they own.

1.4.18 Suspect financial and material abuse when residents:

- have their money spent or their possessions or property used by other people, in a way that does not appear to benefit the resident (for example, their personal allowance being used to fund staff gifts, or misuse of loyalty card points)
- get married or enter a civil partnership, if they are likely to lack capacity to consent to this
- change a will under duress or coercion
- sign a lasting power of attorney when they do not have the mental capacity to make this decision
- personal financial information is not kept confidential.

Discriminatory abuse

1.4.19 Consider discriminatory abuse when residents:

- are denied choices about the care and support that they receive
- are receiving care and support that does not take account of their personal or cultural needs, or other needs associated with protected characteristics under the Equality Act 2010
- show any of the indicators of psychological abuse in recommendation 1.5.11, if these are associated with protected characteristics.

1.4.20 Suspect discriminatory abuse when residents:

- are not treated equitably and do not have equal access to available services
- experience humiliation, violence or threatening behaviour related to protected characteristics
- are not provided with the support they need, for example, relating to their religious or cultural beliefs
- are denied access to independent advocacy
- show any of the indicators of psychological abuse in recommendation 1.4.14, if these are associated with protected characteristics.

For a short explanation of why the committee made the 2020 recommendations on indicators of individual abuse and neglect and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

1.5 Immediate actions to take if you consider abuse or neglect

1.5.1 If you consider abuse or neglect:

- Seek medical attention for the resident if needed.
- Record what you have found.

- Seek advice from a designated safeguarding lead.
- Check whether other indicators have previously been recorded.
- Discuss the welfare of the resident at risk with a manager or supervisor and:
  - if you work in the care home, address the problem yourself
  - if you cannot address the problem yourself or you do not work in the care home, ask the manager or supervisor to address the problem.
- Monitor to see if the problem persists or is repeated, and to check for any other indicators. Think whether new information gives cause for your level of concern to rise from 'consider' to 'suspect'.
- After taking these steps, decide whether there is now a serious concern about the possibility of abuse or neglect. If there is, and if you suspect abuse and neglect, see immediate actions to take if you suspect abuse or neglect.

For a short explanation of why the committee made the 2020 recommendations on immediate actions to take if you consider abuse and neglect and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

1.6 Immediate actions to take if you suspect abuse or neglect

Making sure people are safe

1.6.1 If you suspect abuse or neglect, you must act on it. Do not assume that someone else will.

1.6.2 If you suspect abuse or neglect, make sure that no one is in immediate danger. If there is immediate danger, call 999 and stay with the resident until help arrives.

1.6.3 If a crime is suspected but the situation is not an emergency, encourage and support the resident to report the matter to the police. If they cannot report a suspected crime (for example, because they have been coerced or lack capacity), report the situation to the police yourself.

1.6.4 Depending on the risks the resident is facing, and who the alleged abuser is, think about who should be immediately notified. For example:

- the care home manager
- a healthcare professional or the NHS 111 service if there is a serious medical issue
- the police or other emergency services if the resident is in immediate danger or you suspect a crime.

For a short explanation of why the committee made the 2020 recommendations on making sure people are safe and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Gathering information

1.6.5 As soon as the resident is safe, start gathering information about the suspected abuse or neglect. Write down:

- what happened
- when it happened
- where it happened
- who was involved (the person at risk and the alleged abuser).

1.6.6 Give the resident the chance to speak freely about what has happened. Use simple and open questions, and ask in a non-leading way. Write down what they tell you, in their own words.

1.6.7 Explain the safeguarding process to the resident and discuss the next steps.

1.6.8 Provide emotional support to the resident.

1.6.9 Do not contact the alleged abuser about the incident yourself unless this is essential (for example, if a manager needs to immediately suspend a member of staff).

1.6.10 If a crime is suspected, do not investigate the situation yourself, because this could cause problems for a police investigation. Encourage the resident to preserve any physical evidence (for example, by not washing or bathing).

For a short explanation of why the committee made the 2020 recommendations on gathering information, and how they might affect practice see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Confidentiality and discussing suspected abuse and neglect

1.6.11 If someone discloses abuse or neglect, tell them that you have a responsibility to report your concerns. Tell them who you will report to, why, and when.

1.6.12 If someone discloses abuse or neglect, do not agree to keep secrets or make promises you cannot keep.

Reporting suspected abuse and neglect

1.6.13 If you suspect abuse or neglect, tell a senior member of staff and the safeguarding lead as soon as practical (unless the alleged abuser is the only senior member of staff or the safeguarding lead). If you do not feel confident reporting within the organisation, contact:

- the local authority **or**
- the Care Quality Commission **or**
- a whistleblowing helpline, if available.

For a short explanation of why the committee made the 2020 recommendations on confidentiality and reporting suspected abuse and neglect, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

1.7 Responding to reports of abuse or neglect

Care home safeguarding leads

1.7.1 When abuse or neglect is reported, ask the resident at risk what they would like to happen next. Ensure that the person has access to independent advocacy in line with statutory requirements (see working with advocates). Explain that you have a responsibility to report your concerns to the local authority. Tell them who you will report to, why, and when.

1.7.2 When a safeguarding concern has been reported to you, look at the broader context rather than assessing it in isolation. Take into account:

- if any other people (including children) are at risk as well as the person you are concerned about
- if there have been repeat allegations
- if there could be a criminal offence
- if there is a current or past relationship of trust between the resident and alleged abuser.

1.7.3 When deciding whether to report a safeguarding concern, think about whether the resident's support needs mean they are unable to protect themselves against abuse or neglect. For more information, see the NICE guideline on decision-making and mental capacity.

1.7.4 If you are not sure whether something should be reported as a safeguarding concern to the local authority (because you are not sure

whether you suspect abuse or neglect) discuss with the local authority first.

1.7.5 If you suspect abuse or neglect, you must make a safeguarding referral to the local authority, in line with the Care Act 2014 and Care Act 2014 statutory guidance.

For a short explanation of why the committee made the 2020 recommendations for care home safeguarding leads and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Local authorities

1.7.6 Local authorities should ensure that there is a process for care homes to discuss safeguarding concerns with social workers or other qualified safeguarding practitioners without formally making a safeguarding referral.

1.7.7 Local authorities should consider providing a single point of contact for care homes to seek expert advice on safeguarding (for example, to help decide whether a referral should be made).

1.7.8 Local authorities should be aware that safeguarding referrals may come from a care home's openness and awareness of the safeguarding policy, as well as being possible signs of poor care.

1.7.9 Local authorities and other organisations involved in assessing safeguarding referrals should use professional judgement. They should not be limited in their view of what abuse or neglect is, and should always consider the circumstances of the individual case.

1.7.10 When a safeguarding referral is made, the local authority should decide as quickly as possible whether this meets the legal criteria for a section

42 enquiry. As soon as this is done, they should tell the resident and the care home safeguarding lead what they have decided.

1.7.11 If a section 42 enquiry is not needed, the local authority should think about what other support the resident may need and what the care home may need to do (for example, reviewing the care and support plan and risk management procedures).

1.7.12 If a section 42 enquiry is needed, the local authority should decide who needs to be informed or consulted, depending on the individual context. This might include:

- the resident
- their family and carers
- the care home and care home provider
- advocacy organisations
- voluntary organisations
- the police
- the organisation commissioning care
- the Office of the Public Guardian or Department for Work and Pensions
- specialist helplines or online support, for advice and information
- GPs or other healthcare professionals
- the Care Quality Commission or other regulators
- banks (for financial abuse).

1.7.13 The local authority should set up an initial planning discussion about the safeguarding enquiry with relevant people, and (if appropriate) involve staff from the care home or care home provider.

1.7.14 The local authority should appoint an enquiry lead to coordinate the work of the enquiry and act as a main point of contact.

For a short explanation of why the committee made the 2020 recommendations for local authorities and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in:

- evidence review C: tools to support recognition and reporting of safeguarding concerns
- evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting
- evidence review G: multi-agency working at the operational level in the context of safeguarding.

1.8 Working with the resident at risk during a safeguarding enquiry

1.8.1 At the start of the safeguarding enquiry, the enquiry lead should ask the resident at risk what they would like the enquiry to achieve and how they would like to be involved.

1.8.2 The enquiry lead should ensure that the resident at risk has the chance to review and revise their desired outcomes throughout the process (if needed using speech and language therapy, non-instructed advocacy or other communication and decision-making aids).

1.8.3 Involve the resident at risk, and their family or an appropriate advocate, throughout the enquiry process, in line with their wishes and mental capacity, unless their exclusion can be justified (for example, because of data protection requirements).

1.8.4 For more guidance about supporting decision making for residents who may lack capacity, see the NICE guideline on decision-making and mental capacity.

1.8.5 Make reasonable adjustments to enable residents to fully participate in the safeguarding enquiry, in line with the Equality Act 2010.

1.8.6 Safeguarding Adults Boards and Local Authorities should have auditing processes in place to monitor how residents and their advocates are included in safeguarding enquiries.

Sharing information

1.8.7 The enquiry lead should ask the resident at risk:

- if they would like to be kept up to date during the enquiry
- how much detail they want
- what format they would prefer this in
- who they would like to contact them.

1.8.8 If the police are involved in a safeguarding enquiry, the enquiry lead should hold early discussions with the case officer on the rules of communication and information recording.

1.8.9 When safeguarding enquiries finish, the enquiry lead should provide feedback for the resident (and their families and advocates) that:

- summarises the enquiry, and includes the relevant outcomes and recommendations
- gives them the information needed to decide whether they wish to take any further action (for example, with the Care Quality Commission or Local Government and Social Care Ombudsman).

Working with advocates

1.8.10 For guidance on finding out how residents want to be supported in decision-making, see recommendation 1.2.1 in the NICE guideline on decision-making and mental capacity.

1.8.11 All organisations involved with safeguarding adults in care homes should:

- understand the role of advocacy in relation to safeguarding
- understand that the advocate is the only person who acts solely according to instructions from the resident
- think about the resident's needs and know when to refer people for advocacy

- involve an independent advocate for the resident, when this is required by the Care Act 2014 and Care Act 2014 statutory guidance or the Mental Capacity Act 2005
- ensure that anyone supporting the resident as an informal or independent advocate has been identified in line with the Care Act and the Mental Capacity Act.

1.8.12 Care homes should tell residents:

- how advocates can help them with safeguarding enquiries
- that they may have a legal right to an advocate, and what the criteria for this are.

1.8.13 Practitioners involved in managing safeguarding concerns should build effective working relationships with, advocates and other people supporting the resident.

1.8.14 Safeguarding Adults Boards should monitor:

- whether care homes are telling residents about advocacy and the criteria for accessing this **and**
- how advocates are involved in the management of safeguarding concerns.

Support during an enquiry or investigation

1.8.15 Ask the resident at risk who they would like to support them through the enquiry (in addition to any legal rights to advocacy).

1.8.16 Provide practical and emotional support to the resident at risk:

- while the enquiry is taking place
- when the enquiry has finished, to help deliver the outcomes the person wishes to achieve
- as needed after the enquiry (for example, by updating the care and support plan or protection plan, conducting risk assessments, or through future reviews).

1.8.17 Consider referring the resident for other specialist support (such as psychological support) after the enquiry.

1.8.18 Provide information and support to informal advocates chosen by the resident at risk (for example, family and friends).

1.8.19 Everyone involved with a safeguarding enquiry should remember that the resident is entitled to and may benefit from support (regardless of their mental capacity).

1.8.20 Ensure that the same level of support is offered to residents who self-fund their care and to residents whose care is publicly funded.

1.8.21 Be aware that when the alleged abuser is another resident, they may also need support. Manage the risks between residents while any enquiry takes place.

For a short explanation of why the committee made the 2020 recommendations on working with the resident at risk during safeguarding enquiries, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review D: responding to and managing safeguarding concerns in care homes and evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting.

1.9 How care home providers and managers should support care home staff during an enquiry

Supporting staff who are under investigation

1.9.1 Care home providers and managers should:

- be aware of how safeguarding allegations can affect the way other staff and residents view the person under investigation
- take steps to protect the person from victimisation or discriminatory behaviour.

1.9.2 When a member of staff is under investigation, care home providers and managers should:

- tell them about any available Employee Assistance Programme
- tell them about professional counselling and occupational health services (if available)
- nominate someone to keep in touch with them throughout the investigation (if they are suspended from work).

1.9.3 Staff who are under investigation should be able to request that the nominated person be replaced, if they think there is a conflict of interest.

1.9.4 The nominated member of staff should not be directly involved with the investigation.

1.9.5 If the police are involved, care home providers and managers should tell them who the nominated member of staff is.

1.9.6 For members of staff who return to work after being suspended, care home providers and managers should:

- arrange a return-to-work meeting when the enquiry or investigation is finished, to give them a chance to discuss and resolve any problems
- agree a programme of guidance and support with them.

For a short explanation of why the committee made the 2020 recommendations on supporting care home staff who are under investigation, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting.

Supporting care home staff

1.9.7 Unless they are under investigation themselves, care home managers should:

- find out from the local authority what they can share with staff at each stage of the safeguarding enquiry
- communicate as much as possible with all staff about the enquiry, and be open to answering questions.

1.9.8 Care home managers should support staff by:

- acknowledging that safeguarding enquiries are stressful and that morale may be low
- providing one-to-one supervision and team meetings
- providing extra support to cover absences as part of the enquiry and to help staff continue providing consistent and high-quality care.

1.9.9 If a care home manager is under investigation, the care home or care home provider should put an acting manager in their place.

1.9.10 If staff are concerned about working with a resident who has made allegations, care home managers should:

- provide support, additional training and supervision to address these concerns
- ensure that the resident is not victimised by staff.

1.9.11 Care home managers should direct staff to sources of external support or advice if needed.

For a short explanation of why the committee made the 2020 recommendations on supporting care home staff during an enquiry, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting.

1.10 How local authorities should support care homes during an enquiry

1.10.1 Local authorities should ensure that there is a single point of contact to keep the care home informed about the progress of the safeguarding enquiry.

1.10.2 Local authorities should be aware of the reputational impact on the care home's business (for example, on recruitment, resourcing and financial losses), and ensure that their actions are timely and proportionate.

1.10.3 Local authorities should be aware that care home staff may be anxious about their job security because of a safeguarding enquiry.

1.10.4 Local authorities should offer:

- positive feedback to care homes when they handle safeguarding concerns well
- practical support to care home staff, to help with safeguarding enquiries.

1.10.5 Local authorities should share the outcomes of safeguarding enquiries with commissioners, so that they can incorporate the findings into their own decisions (for example, whether to lift a placement embargo).

For a short explanation of why the committee made the 2020 recommendations for local authorities on supporting care homes during safeguarding enquiries, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting.

1.11 Meetings during a safeguarding enquiry

1.11.1 Only exclude people from a meeting if this is in accordance with the safeguarding policy. If people have to be excluded from a safeguarding

meeting, explain why and give them a chance to share their views in another way.

1.11.2 If the care home manager and the care home provider safeguarding leads are not at a safeguarding meeting, the chair should ensure they are informed of the outcome and the reasons behind it.

1.11.3 Keep the resident at risk informed about the outcome of the meetings. If the outcome is not what the resident was expecting, the chair should take particular care to explain the reasons behind it.

For a short explanation of why the committee made the 2020 recommendations on safeguarding meetings during an enquiry and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review D: responding to and managing safeguarding concerns in care homes and evidence review G: multi-agency working.

1.12 Indicators of organisational abuse and neglect

This section describes indicators that should alert people to the possibility of organisational abuse in a care home, and immediate actions that should be taken. It does not go into detail about the process for raising a concern, making a referral or conducting an enquiry. This process will vary depending on the nature of the allegations, and the local arrangements in place for responding to such allegations.

There is no one size fits all approach for managing and responding to organisational abuse. This is because of the huge range of actions and inactions that may contribute to organisational abuse, at all managerial and financial levels within care provider organisations. Organisational abuse can also be caused by a single act of neglect or omission. However, commissioners should be alert to any allegations of organisational abuse within care homes, as part of their responsibility for monitoring standards of care against contractual requirements.

Organisational abuse (also known as institutional abuse) is distinct from other forms of abuse or neglect, because it is not directly caused by individual action or

inaction. Instead, it is a cumulative consequence of how services are managed, led and funded. Some aspects of organisational abuse may be hidden (closed cultures), and staff may act differently when visitors are there (disguised compliance). Organisational abuse can affect one person or many residents. Therefore, it is important to consider each unique case, and the impact on individual residents as well as the whole care home.

The terms ‘consider’ and ‘suspect’ are used to define the extent to which an indicator suggests abuse or neglect, with 'suspect' indicating a stronger likelihood of abuse or neglect.

- To ‘consider’ abuse or neglect means that this is one possible explanation for the indicator.
- To ‘suspect’ abuse or neglect means a serious level of concern about the possibility of abuse or neglect.

None of the indicators are proof of abuse or neglect on their own.

When to consider abuse or neglect

Lack of safeguarding policy, procedure, accountability or governance

1.12.1 Consider organisational abuse when:

- safeguarding leadership or governance arrangements are unclear (for example, there is no registered manager or delegated safeguarding lead)
- managers rarely or never observe their staff at work, or are rarely or never available to speak to residents (or their families and carers), staff, and other professionals
- the care home does not have policies and procedures covering:
  - safeguarding
  - whistleblowing
  - complaints
- the care home policy and procedure on safeguarding is inconsistent with the Care Act 2014 or this guideline

- residents, visitors, staff and other people working with care homes do not have access to safeguarding and other policies and procedures covering the protection and safety of residents
- the care home does not explain the concepts of safeguarding, abuse and neglect to residents
- residents are not involved in how the care home is run.

Not meeting contractual or regulatory standards

1.12.2 Consider organisational abuse when care homes:

- do not meet contractual safeguarding standards
- do not meet regulatory standards (such as Care Quality Commission standards)
- fail to improve or respond to actions or recommendations in local inspections or audit frameworks (from clinical commissioning groups or the local authority) or reviews and inspections (by the Care Quality Commission or Healthwatch)
- fail to sustain improvements
- do not monitor the quality of their care against Care Quality Commission quality standards, for example, using surveys, meetings and other community engagement (such as open days and visits).

Mismanagement of safeguarding concerns and poor record-keeping

1.12.3 Consider organisational abuse when:

- safeguarding issues are not always reported
- no audits or actions are taken after a disclosure
- there is no clear safeguarding policy or information about how to raise a safeguarding concern
- serious incidents are not reported (for example, unexplained deaths, serious fires, or infectious disease outbreaks)
- there is a lack of safeguarding concerns recorded or referrals made
- the care home has poor or outdated records

- there are inconsistent patterns of safeguarding concerns logged (for example, if all concerns originate from 1 member of staff, then other staff may not be taking enough responsibility for safeguarding)
- safeguarding concerns have been reported via complaints procedures rather than through safeguarding procedures
- the care home does not comply with Mental Capacity Act requirements on deprivation of liberty and liberty protection safeguards.

Staffing

1.12.4 Consider organisational abuse when:

- the care home does not have clear, safe recruitment processes (including reference checks and enhanced Disclosure and Barring Service checks)
- staff are not properly supervised and supported, or there is no documentation that this is happening
- there is no evidence that safeguarding training or induction is taking place
- there are high rates of staff absence
- staff work excessive hours without enough breaks
- staff are working under poor conditions
- there is high staff turnover and high dependency on contract or temporary staff.

Quality of care and service provision

1.12.5 Consider organisational abuse when:

- there is evidence of poor medicines management (for example, excessive use of 'as needed' medicines)
- restrictive practice is used:
  - residents are prevented from moving around the home freely or independently

  - staff teams have inflexible and non-negotiable routines that do not take account of what individual residents want or need
  - staff do not help residents live as independently as they can
- meaningful and structured activities for residents are not available or accessible
- behaviours of concern are mismanaged (for example, overuse of restrictive practices, including misuse of medication)
- care and support plans are changed suddenly, without discussion with residents or others involved with their care
- residents do not receive person-centred care (for example, care is focused on completing tasks and ignores individual circumstances and preferences)
- staff routinely make assumptions about residents or their needs, and miss hidden needs or disabilities
- staff do not respond to requests from residents, or interfere with residents' preferences and choices
- residents are reluctant to ask for changes or to make complaints
- certain residents routinely receive preferential treatment over others
- there are general inconsistencies in the standard of service provision.

Failure to refer for appropriate care or support

1.12.6 Consider organisational abuse when:

- residents miss appointments or are not referred to other professionals or services (such as GPs or dentists)
- people who require independent advocacy are denied access to it.

Financial mismanagement and lack of investment

1.12.7 Consider organisational abuse when:

- there are not enough staff on each shift to meet the needs of residents
- care home equipment is inadequate or poorly maintained
- the care home admits or accepts referrals for residents that staff do not have the skills to care for

- there is a lack of investment in the services the care home provides, compared with the fees it charges
- resources (such as one-to-one support) for residents with assessed needs are not provided, despite funding being allocated for this
- resident's money is not adequately protected (for example, personal allowances).

Physical signs and lack of openness to visitors

1.12.8 Consider organisational abuse when:

- the care home is dirty or smelly, or is not compliant with basic infection control (for more information about infection control see the NICE quick guide on Helping to Prevent Infection)
- call bells have been removed or are routinely overused
- there is a lack of engagement with visitors, or places in the care home that visitors are not allowed to see
- there is a lack of engagement with the organisation the care home is part of.

1.12.9 For indicators starting with 'consider'

- raise the matter with the care home manager (unless they are believed to be part of the problem), in writing if possible
- explain the impact on residents, or the likely impact if the situation continues
- ask for a response within a specified period of time (for example 2 weeks).
- if the manager agrees to make changes, make sure these happen
- after taking these steps, if the situation does not improve, raise your level of concern to 'suspect'.

When to suspect organisational abuse or neglect

1.12.10 Suspect organisational abuse when:

- incidents of abuse or neglect are not reported, or there is evidence of incidents being deliberately not reported
- there is evidence of redacted, falsified, missing or incomplete records
- there have been multiple hospital admissions of residents, resulting in safeguarding enquiries
- there are repeated cases of residents not having access to medical or dental care
- there is frequent, unexplained deterioration in residents' health and wellbeing
- residents' money is being misused by the care home (for example, to purchase gifts for staff or other residents without permission)
- there is a sudden increase in safeguarding concerns in which abuse has been identified
- residents are repeatedly evicted or threatened with eviction after making complaints
- repeated instances of residents, families and carers feeling victimised if they raise safeguarding concerns
- the care home fails to improve or respond to actions or recommendations in local inspections or audit frameworks (from clinical commissioning groups or the local authority) or reviews and inspections (by the Care Quality Commission or Healthwatch) **and** deteriorates over time.

1.12.11 If you suspect abuse or neglect:

- Contact your local authority and tell them that you want to make an adult safeguarding referral.
- Local authorities who receive adult safeguarding referrals should gather information under section 4 of the Care Act. They must decide if there is reasonable cause to suspect that an adult with care and support needs is experiencing abuse or neglect and is unable to protect themselves from harm. If this criteria is met, the Local Authority must conduct a section 42 enquiry.

- If many residents of a care home are affected, local authorities may conduct a large-scale enquiry, following their own local procedures.
- If you are not satisfied with the response from your local council, report the matter to the Care Quality Commission.

1.12.12 When organisational abuse or neglect is identified, plan what individual or collective support is needed for residents, staff, and other people who might be affected.

For a short explanation of why the committee made the 2020 recommendations on indicators of organisational abuse and neglect, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

1.13 How care homes should learn from safeguarding concerns, referrals and enquiries

1.13.1 Care home managers and managers from local agencies should help their organisations to identify key lessons from the outcome of any safeguarding concern, referral, enquiry, or Safeguarding Adult Review.

1.13.2 Care home managers should incorporate learning from safeguarding concerns, referrals and enquiries into the care home culture at all levels:

- individual staff (for example, through changes to support, supervision, retraining, and performance management)
- care home (for example, through observations of practice, discussion and watching people work across the home, and through implementation of changes to practice, procedure, policy and learning and group training including from other health and social care practitioners)
- care home provider (for example, through policy changes).

In addition, see the recommendations on care home culture, learning and management.

For a short explanation of why the committee made the 2020 recommendations on learning from safeguarding concerns, referrals and enquiries, and how they might affect practice, see rationale and impact.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning about safeguarding.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary and the Think Local, Act Personal Care and Support Jargon Buster.

Care homes

Residential care homes (with or without nursing care) that are registered with and regulated by the Care Quality Commission.

Care home providers

Companies that own and operate one or more care homes regulated by the Care Quality Commission.

Commissioners

Local authorities, clinical commissioning groups and other public sector commissioners who oversee contracts for care and support services provided by care homes that pay for care home residents who are eligible for public funding. The term 'commissioner' does not apply to individuals who pay privately for their care.

Contract or temporary staff

Staff who are not employed on a permanent contract with the care home, who may be supplied by an employment agency on a short-term basis, or who might be employed on a zero hours contract or on a casual labour basis.

e-learning

Induction, training and assessment that people undertake on a computer or mobile device, without interacting with other people.

Enquiry lead

Sometimes referred to as the lead enquiry officer or enquiry officer. This person is appointed by the local authority when a safeguarding enquiry begins and may be a local authority social worker or a designated member of staff from the care home or care home provider. They are responsible for coordinating responses to the enquiry, coordinating decision making and acting as a main point of contact. They make sure that enquiry actions are undertaken in accordance with Care Act duties, related statutory guidance and the recommendations in this guideline.

Face-to-face learning

Induction, training and assessment that is performed one-to-one, or in groups led by either in-house staff experts, managers or external trainers. It may take place with participants all in the same room, or by using video or telephone conferencing. It may include online materials, but participants are able to ask questions, discuss, reflect on current practice and use case studies and examples. This type of training looks at how safeguarding relates to the particular role of the person being trained, and to the personalised care and support needs of residents.

Multi-agency

Agencies are organisations and services who are involved in safeguarding adults in care homes. This includes social care and health service providers, the police and others involved in the criminal justice system, education and learning providers, advocacy services and local voluntary and community groups. Agencies may also include national organisations or complaints services such as the Ombudsman. When agencies work together, this is known as multi-agency working.

Reflective practice and reflective supervision

Opportunities for staff to:

- reflect on previous practice

- talk about why they made the decisions they made, and why they acted or behaved in particular ways
- talk about their their emotional responses to their actions and the actions of others
- engage in continuous learning.

Reflective practice or supervision may also provide insight into personal values and beliefs, and help staff understand how these influence action and decision making within the care home.

Registered managers

Care homes registered with the Care Quality Commission must have a registered manager in line with the Health and Social Care Act 2008. The registered manager is responsible for leading and running the care home and making sure that standards are upheld. Other managers may also work within care homes and have responsibilities for staff supervision, line management or other aspects of running of the home, but the registered manager is accountable to the Care Quality Commission for the standards of care and safeguarding within the home.

Residents

Adults aged 18 and over who live in and receive care and support in care homes, or who use care homes to access care and support from time to time (for example respite care, including day care).

Resident at risk

The resident at the centre of a safeguarding concern, when:

- abuse or neglect is considered or suspected **or**
- a safeguarding referral has been made to a local authority **or**
- a section 42 safeguarding enquiry is taking place.

Safeguarding champions

Safeguarding champions are staff already working within the care home, with good knowledge of safeguarding policy and procedure, who help ensure that procedures are followed and are available for discussion. They also ensure reflective learning

about best practice in preventing abuse and neglect. Champions may also offer practical and emotional support to those worried about the impact of raising concerns. They are not a replacement or alternative to the safeguarding lead.

Safeguarding concern

A consideration, suspicion or indication of abuse or neglect of a resident, or residents within a care home. Anybody who works in, lives in or visits the home may have a safeguarding concern, either because of something they have seen or because of something they were told. All safeguarding concerns should be responded to in line with this guideline.

Safeguarding enquiry

If the local authority agrees that the safeguarding referral falls within the duties for local authorities (set out within the Care Act 2014 and related statutory guidance), the local authority must undertake a section 42 enquiry into the suspected abuse or neglect.

Safeguarding lead

This may be the care home registered manager or those with delegated responsibility for safeguarding within the care home. It is a statutory requirement for care homes to have a designated safeguarding lead.

Safeguarding referral

If abuse or neglect is suspected this must be reported to the local authority. This is called making a safeguarding referral.

Service providers

Other organisations providing services within care homes or contracted by care homes to provide services. These include health and social care services (for example, GP services, clinical psychology and occupational therapy) but also other services such as cleaning, catering, gardening, transport, education, learning or activities.

Staff

Anyone paid to work in a care home and involved either directly or indirectly in the care and support of residents. This includes care workers, nurses, managers, administrative staff, cleaners, caterers, gardeners or anyone else who the care home employs directly or via agencies, contractors, on a casual, part-time, full-time, temporary or permanent basis.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Indicators of self-neglect

What are the indicators of self-neglect among care home residents, and what should the responses be?

For a short explanation of why the committee made the research recommendation on indicators of self-neglect see rationale and impact.

Full details of the research recommendation are in evidence review A: Indicators of abuse and neglect.

2 Local authority or provider led enquiries

What is the effectiveness and cost effectiveness of local authority versus provider-led safeguarding enquiries?

For a short explanation of why the committee made the research recommendation on local authority or provider led enquiries see rationale and impact.

Full details of the research recommendation are in evidence review D: Responding to and managing safeguarding enquiries.

3 Person centred and outcome focused enquiries

To what extent are safeguarding enquiries in care homes person centred and outcomes focused, and what improvements could be made?

For a short explanation of why the committee made the research recommendation on person-centred and outcome-focused enquiries see rationale and impact.

Full details of the research recommendation are in evidence review D: Responding to and managing safeguarding enquiries.

4 E-learning safeguarding training

What is the effectiveness, cost effectiveness and acceptability of e-learning safeguarding training compared with face-to-face?

For a short explanation of why the committee made the research recommendation on online safeguarding training see rationale and impact.

Full details of the research recommendation are in evidence review H: The effectiveness and acceptability of safeguarding training.

5 Embedding learning from Safeguarding Adults Reviews

What are the barriers and facilitators in care homes to embedding learning from Safeguarding Adults Reviews?

For a short explanation of why the committee made the research recommendation on embedding learning from Safeguarding Adults Reviews see rationale and impact.

Full details of the research recommendation are in evidence review I: Embedding organisational learning about safeguarding.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Care home safeguarding policy and procedure

Recommendations 1.1.1 to 1.1.5

Why the committee made the recommendations

These recommendations are based on:

- qualitative themes from research evidence
- the committee's own expertise and experience
- health and social care guidance
- the Care Act 2014 and Care Act 2014 statutory guidance.

Overall, the committee's confidence in the research evidence was low. The main issues with the evidence were that the included studies provided only limited data and reported research conducted in a range of settings, making it difficult to determine whether each finding was directly relevant to care home contexts. There were also concerns regarding the methods used in some of the included studies, for example their recruitment processes and how they considered the wider research context.

The committee also reviewed existing non-NICE UK health and social care guidance. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to inform the recommendations, alongside their own expertise and experience. The guidance highlighted some of the challenges faced by individuals and organisations when there is no clear safeguarding procedure. This has implications for:

- the safety and wellbeing of residents, because abuse or neglect may go unreported
- the wellbeing of staff, because they can feel anxious and unsupported when they do not know what to do about safeguarding concerns.

The committee were keen to highlight the obligations of individuals (including visitors) and organisations, to ensure that everyone knows what to do when a safeguarding concern arises. The committee made a recommendation on ensuring that the safeguarding policy is easy to find and understand because safeguarding is everyone's responsibility, and people with little experience of safeguarding (such as visitors) may need to read it.

While having policies and procedures in place is important, care homes and care home providers can have problems ensuring that staff follow these. The committee believed it was important to have systems in place to make sure policies and procedures are followed. They made recommendations on how these systems should be used to record and share information.

How the recommendations might affect practice

Care homes should already have a safeguarding policy and procedure and recommendations reflect statutory requirements. However, some care homes may need to change their policy and procedure so that they fully comply with these recommendations. This may involve extra work for care home managers. Training may also be needed for care home staff, to promote greater understanding of safeguarding policy and procedure.

Full details of the evidence and the committee's discussion are in:

- evidence review B: barriers and facilitators to identifying abuse and neglect
- evidence review D: responding to and managing safeguarding concerns in care homes
- evidence review C: tools to support recognition and reporting of safeguarding concerns and evidence review.

Return to recommendations

Care home whistleblowing policy and procedure

Recommendations 1.1.6 to 1.1.9

Why the committee made the recommendations

The committee used qualitative themes from research evidence on identifying abuse and neglect to make the recommendations. There were several issues with this evidence. The main concern was relevance, as it was not always clear whether the data reported came from research conducted in a care home setting. There were also concerns regarding the methods used in some of the studies, for example in relation to their recruitment and data analysis processes.

The committee also reviewed existing non-NICE UK health and social care guidance. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to inform the recommendations. The guidance highlighted the challenges associated with whistleblowing and the impact whistleblowing can have on care homes, staff and residents. The committee felt that this was an important area, and built on the evidence using their own expertise. Good whistleblowing policies are important and help support a culture in which staff feel able to report concerns.

Based on their own knowledge, the committee decided to emphasise the legal protections for whistleblowers. This is because whistleblowers are vulnerable to victimisation, particularly if they are residents of the care home (who may be threatened with eviction for making a complaint).

How the recommendations might affect practice

Care homes may need to revise and update their whistleblowing policy and procedure. They may also need to do more to promote more positive attitudes about whistleblowing among staff, and to encourage an open culture to help staff feel more confident raising concerns. In turn, this should help reduce the under-reporting of safeguarding concerns.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

Care home and care home provider roles and responsibilities

Recommendations 1.1.10 to 1.1.14

Why the committee made the recommendations

Qualitative themes were identified from the research evidence, covering the challenges associated with governance, roles and responsibilities, and lines of communication. There were a number of issues that limited how the committee

could use the findings. The main issues were the adequacy of the data and the relevance of the evidence, as it was not always clear whether data had been collected in a care home setting.

In addition, there were concerns about methods used in some of the studies, for example in relation to data analysis processes and how the researchers took account of ethical issues.

The evidence did, however, highlight the uncertainties and misunderstandings surrounding the roles and responsibilities for safeguarding within care homes and care home providers. The committee agreed that this is a crucial area and they built on the evidence with their own expertise.

How the recommendations might affect practice

Care homes will need to ensure they implement relevant, up-to-date policies and procedures. This should only require minor changes to current practice because it is already a statutory requirement.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review F: barriers and facilitators to effective strategic partnership working.

Return to recommendations

Local authorities, clinical commissioning groups, and other commissioners

Recommendations 1.1.15 to 1.1.17

Why the committee made the recommendations

The committee agreed that it is important to reiterate the responsibilities of local authorities, clinical commissioning groups and other public sector commissioners, because they can use contract monitoring and other statutory monitoring processes to ensure that care homes are meeting their safeguarding responsibilities.

The committee also wanted to emphasise the important role of commissioners in working with care homes. Commissioners can help care homes implement lessons

learnt from Safeguarding Adults Reviews and ensure that good safeguarding records are maintained.

How the recommendations might affect practice

Local authorities, clinical commissioning groups and other commissioners should already be monitoring safeguarding in care homes as part of contract management, so this should not represent a significant change in practice. Commissioners may need to do more to promote good communication and working relationships with care homes, but this could be achieved without additional resources.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators to identifying abuse and neglect and evidence review F: barriers and facilitators to effective strategic partnership working.

Return to recommendations

Safeguarding Adults Boards

Recommendations 1.1.18 to 1.1.22

Why the committee made the recommendations

The committee made the recommendations based on a limited amount of qualitative evidence on the roles and responsibilities of Safeguarding Adults Boards. There were a number of concerns with this evidence, around:

- the methods used, for example in relation to data analysis and sampling strategies
- the relevance of the themes in the evidence, as some of the studies were conducted in care settings other than care homes
- adequacy, as the themes were based on relatively limited data.

The evidence highlighted the challenges associated with partnership working, and the difficulties in communicating with and involving care homes in safeguarding enquiries. The evidence also indicated that there may sometimes be confusion around:

- how to manage safeguarding concerns

- which organisation is responsible for each part of the process
- how and when care homes should be working with the local Safeguarding Adults Board.

How the recommendations might affect practice

There is wide variation in the way Safeguarding Adults Boards operate and communicate with care homes. The recommendations should lead to greater consistency. Safeguarding Adults Boards should not need additional resources, but some will need to change the way they work. If they are not already doing so, they will need to promote a positive culture and encourage greater collaboration between their members and partner organisations, especially care homes.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting and evidence review F: barriers and facilitators to effective strategic partnership working.

Return to recommendations

Induction and training in care homes

Recommendations 1.2.1 to 1.2.6

Why the committee made the recommendations

Quantitative and qualitative data were available on training in the care sector, but the committee's confidence in this evidence was low. For the quantitative data, this was mostly because of the use of non-randomised trials and imprecision in effect estimates. For qualitative findings there was a shortage of evidence, with only limited data from a small number of studies. In addition, there were issues with the relevance of the qualitative data, because some studies may have been conducted outside of care homes, and some findings may not have been specifically related to safeguarding.

As a result of the limitations of the evidence, the committee also used their own expertise and statutory guidance requirements to make a recommendation. They

believed this is important because good quality training can have a big impact on safeguarding practice and the safety and wellbeing of care home residents.

The evidence highlighted the need for basic training for all staff employed by the care home, to make sure they have a good understanding of what safeguarding is, how it is everyone's responsibility and how it might relate to their job within the care home.

Mandatory training is required to fulfil Section 14.225 of the Care and support statutory guidance 2020, and each organisation is responsible for ensuring that staff receive effective training. The committee discussed whether it is possible to specify how soon new staff should have mandatory safeguarding training. Although there was no evidence on this the committee agreed it would be helpful to specify that this should take place within 6 weeks of starting work. This is in line with standards that already exist, such as Adult Safeguarding: Roles and competencies for Health Care Staff 2018, but there is still inconsistent practice in this area. Evidence suggested that improvements in safeguarding practice were not always maintained in the longer-term, and the committee agreed that it was important to annually refresh knowledge about good practice in safeguarding.

How the recommendation might affect practice

Care Quality Commission standards cover basic safeguarding training for all staff (CQC: Safeguarding Adults - Roles and responsibilities in health and care services) so this is not a new requirement and is unlikely to lead to significant resource implications. However, the content of training may vary across care homes, and some care homes may need to adapt their training programmes to make sure that safeguarding forms part of all new employee inductions within 6 weeks of starting work. Training programmes may also need to be adapted to ensure that staff are given protected time to ensure they fully understand the actions they need to take if they ever have a safeguarding concern.

There may also be minor resource implications associated with improved safeguarding practice. For example, if staff have a better understanding of abuse and neglect, they may raise more concerns and there may be an increase in safeguarding referrals and enquiries.

Full details of the evidence and the committee's discussion are in:

- evidence review B: barriers and facilitators to identifying abuse and neglect
- evidence review H: the effectiveness and acceptability of safeguarding training
- evidence review I: embedding organisational learning about safeguarding.

Return to recommendations

What mandatory training should cover

Recommendations 1.2.7 to 1.2.9

Why the committee made the recommendations

The strength of the evidence was limited, but the committee made recommendations in areas where the evidence aligned with their own experience and expertise.

The committee had low confidence in the quantitative outcomes, because of concerns about bias (as most studies were not randomised) and imprecision in effect estimates. They were also concerned about the short follow-up periods the studies used.

There were also issues with the qualitative evidence. This was mainly due to the relevance of the data, because it was not always clear whether findings related specifically to safeguarding. There were also concerns regarding the adequacy of data, as most of the themes in the evidence were based on limited data.

The evidence suggested that in some care homes, training only covers a basic understanding of adult protection policies and procedures, which staff may not then know how to apply in their daily work. To address this and ensure that staff have a more thorough understanding of safeguarding, the committee specified the different areas that need to be covered in training programmes for all staff.

How the recommendations might affect practice

Care homes may need to change their safeguarding training programmes to make sure they cover the areas included in this guideline. They may need to make training programmes applicable to the daily practice and responsibilities of staff and

particularly to safeguarding in the care home environment. Care homes will need to make sure that safeguarding terminology is clearly understood by staff whose first language is not English, which may require some additional resources.

Full details of the evidence and the committee's discussion are in:

- evidence review B: barriers and facilitators to identifying abuse and neglect
- evidence review H: the effectiveness and acceptability of safeguarding training
- evidence review I: embedding organisational learning about safeguarding.

Return to recommendations

Further training

Recommendation 1.2.10

Why the committee made the recommendations

There was quantitative and qualitative evidence available, but the committee had limited confidence in this.

The quantitative evidence had issues with bias (as most studies were not randomised) and imprecision in effect estimates. In addition, the studies only used short-term follow-up periods.

There were issues with the relevance of the qualitative data, as it was not always clear whether findings related specifically to safeguarding. There were also concerns regarding adequacy, as most themes were based on limited data.

Because of the limitations with the evidence, the committee also used their expertise when making recommendations on further training.

Evidence on training suggested that improvements in safeguarding practice were not always maintained in the longer-term, and that there should be opportunities for further and more advanced learning. As a result, the committee agreed that it is important to emphasise that training should not be a one-off event. Their recommendations included advice about further training that may be beneficial for some staff. More detailed information on safeguarding training and the competencies that different staff need is covered in Adult Safeguarding: Roles and

competencies for Health Care Staff 2018. Because of this, the committee did not make recommendations about who should have further training or when this should happen.

How the recommendations might affect practice

Ensuring that care home staff can regularly take part in safeguarding training may lead to an increase in resource use, particularly if care homes choose to use external organisations to deliver these programmes. However, increased costs will be justified given the improvements in safeguarding practice that are likely to occur.

There may be an increase in the number of requests for training. There may also be cost implications if practitioners need training of their own in order to conduct training for staff, or if external organisations are used to deliver training. In addition, some staff posts may need to be back-filled while training takes place. However, any additional costs may be justified by the improvements in staff knowledge, competence and confidence, which will provide better quality of care for residents.

Full details of the evidence and the committee's discussion are in evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting and evidence review H: the effectiveness and acceptability of safeguarding training.

Return to recommendations

How to conduct training

Recommendations 1.2.11 to 1.2.17

Why the committee made the recommendations

There was only limited evidence that focused specifically on safeguarding training in the care sector. There was no evidence comparing the effectiveness of different modes of training (for example e-learning programmes compared with group sessions). The committee provided anecdotal evidence of concerns about the efficacy of e-learning, in particular when there is no opportunity for discussion and human interaction. They agreed that further research is needed to evaluate the most effective modes of training, and to clarify whether e-learning training can meet

best practice standards. To address this, the committee made a research recommendation to look at the effectiveness, cost effectiveness and acceptability of e-learning safeguarding training, compared with face-to-face training.

There was some limited economic evidence on training. This evidence did not demonstrate any differences in costs or effectiveness between 2 different programmes. An economic analysis showed that face-to-face training could be cost-effective relative to e-learning, under certain assumptions. Other evidence that was available highlighted the positive outcomes achieved with some training methods (such as case studies and examples), and the challenges associated with other types of training (such as e-learning). The committee supported this evidence with their own expertise.

The recommendations should help care home managers identify the most appropriate training methods for their staff, which will improve care home practice.

How the recommendations might affect practice

There is some variation across the UK in the way care homes conduct training, although the contracts that providers have with local authorities will tend to encourage best practice and standardisation.

There may be an increase in the number of requests for training. There may also be cost implications if practitioners need training of their own in order to conduct training for staff, or if external organisations are used to deliver training. However, any additional costs will be justified by the improvements in staff knowledge, competence and confidence, which will provide better quality of care for care home residents.

Full details of the evidence and the committee's discussion are in evidence review H: the effectiveness and acceptability of safeguarding training and evidence review I: embedding organisational learning.

Return to recommendations

Evaluating training

Recommendations 1.2.18 to 1.2.20

Why the committee made the recommendations

Although there was some quantitative evidence on the effectiveness of safeguarding training, there were concerns with this evidence. The main concerns were around bias (as most studies were not randomised) and imprecision in effect estimates. There were also concerns regarding the short-term follow-up periods used by the studies.

The qualitative evidence also had problems. There was a lack of detail regarding study methodology, making quality assessment difficult. The committee had concerns about the adequacy of the findings, which were based on 'thin' data. And it was unclear whether the data related specifically to safeguarding.

Because of the shortage of good-quality evidence, the committee made recommendations partly based on their own expertise and experience.

Despite the limitations of the evidence, the qualitative data indicated that training can improve staff safeguarding skills. This was also reflected in the qualitative evidence, which indicated that practitioners recognised the value of safeguarding training. However, this evidence also suggested that managers may be unwilling to implement learning from training programmes or make changes to care home procedures, which may negate any benefits associated with training. To address this, the committee made a recommendation on how managers should encourage staff to complete training.

The evidence on training only included short-term measurements of effectiveness. To address this potential issue, the committee made a recommendation on assessing how well training is working and whether it is being used to improve practice. For example, care home managers could assess this through follow-up conversations with staff, and by evaluating changes immediately after training and at further longer-term follow-up.

How the recommendations might affect practice

Care home managers may need to re-assess how they engage with safeguarding training. They will need to find ways to identify positive changes from training, and implement these across the care home. This may mean that managers have to

place greater emphasis on reflective practice and shared learning among staff. The structure of staff supervision sessions may need to be changed, to ensure that positive learning is acknowledged and reinforced.

Full details of the evidence and the committee's discussion are in evidence review H: the effectiveness and acceptability of safeguarding training and evidence review I: embedding organisational learning.

Return to recommendations

Management skills and competence

Recommendations 1.3.1 to 1.3.2

Why the committee made the recommendations

Some qualitative evidence was available, but the committee had limited confidence in it. This was mostly due to issues with:

- the study methods, such as the processes used to analyse the data
- the relevance of the data, as it was not clear whether data was specific to safeguarding (rather than more general quality of care) or whether data had been generated in care settings other than care homes
- the adequacy of the data, which was considered to be limited (and did not include any quotations).

As a result, the committee drew on their own expertise to supplement the evidence and make recommendations.

The evidence indicated that care home managers can play a key role in influencing the attitudes of their staff and colleagues towards training. Some staff may also need more support to benefit from training. Staff may not benefit from training if managers are unable or unwilling to allow staff to implement what they have learned within the care home and share their experience with other members of staff.

How the recommendations might affect practice

Managers will need to make sure their safeguarding knowledge is up to date. This has been a legal requirement for some time so should not represent a change in practice.

There is variation in how much care home managers do to encourage other staff to learn more about safeguarding. The recommendations will help standardise practice, and ensure that managers promote safeguarding training and learning in care homes.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning.

Return to recommendations

Line management and supervision

Recommendations 1.3.3 to 1.3.7

Why the committee made the recommendations

There was a good amount of qualitative evidence on identifying abuse and neglect in care homes, and the barriers and facilitators to this. In particular, the evidence looked at the concept of whistle-blowing and the reasons why care home staff may be reluctant to report concerns (for example, fear of losing their job).

There were some issues with this evidence. There were issues with the methods used by some studies, such as their recruitment strategies and data analysis processes. Some of the included research was not conducted in care home settings, so there were concerns about how relevant it was. And some of the studies provided limited data, which led to issues with the overall adequacy of the data.

The committee therefore drew on their own experiences when drafting recommendations, with the aim of helping managers to increase staff confidence in identifying and raising safeguarding concerns.

How the recommendations might affect practice

Reflective supervision is already a key feature of broader social work, but the extent to which it takes place in care homes is extremely varied. These recommendations will help standardise the use of reflective supervision. Care home managers may need to do more to support staff who are reluctant to raise concerns.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning about safeguarding and evidence review B: barriers and facilitators to identifying abuse and neglect.

Return to recommendations

Care home culture

Recommendations 1.3.8 to 1.3.12

Why the committee made the recommendations

There was a good amount of qualitative evidence on the barriers and facilitators to identifying abuse and neglect in care homes. There were concerns with:

- the appropriateness of some methods used by the studies, such as recruitment strategies and data analysis processes
- the relevance of the data, because some of the research was not conducted in care home settings
- the adequacy of the data, because some of the included studies provided limited data.

This research did not specifically evaluate the impact that care home culture can have on staff willingness to report safeguarding concerns. However, the committee agreed that the culture of a particular care home (and the role played by managers in shaping this) is a key factor in enabling and encouraging care home staff to report safeguarding concerns.

The committee suggested 'safeguarding champions' as a way to provide more informal support for people worried about the impact of raising concerns. This is in additional to the formal and mandatory role of safeguarding lead.

The evidence also included data on how to reduce the risk or incidence of abuse and neglect by learning from past safeguarding issues in the care home. The committee agreed that this should be encouraged at all levels, to help create a care home culture where safeguarding is central and transparency is established. The committee also wanted care homes to reflect on and learn from Safeguarding Adults Reviews.

The committee recommended care homes should ask for feedback from residents and families to find out what they thought about the way that safeguarding issues were addressed and managed in the home. It is important that this is used routinely to help improve safeguarding practices.

Staff are encouraged to watch out for changes in the mood and behaviour of residents because many indicators of abuse and neglect are quite subtle physical or emotional changes or traits.

How the recommendations might affect practice

Some care homes have a positive, open culture, in which staff and others are supported to reflect on, identify and report safeguarding concerns. For care homes where this is not the case, care home managers and care home providers will need to make major changes in leadership style. Additional resources should not be needed for care homes to appoint safeguarding champions, because the champions are expected to be existing staff members.

Creating a culture in which everyone can learn from safeguarding concerns should not represent a significant change. However, it will bring care homes in line with best practice, particularly in terms of supervision and continuing professional development.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning and evidence review B: barriers and facilitators to identifying abuse and neglect.

Return to recommendations

Multi-agency working and shared learning with other organisations

Recommendations 1.3.13 to 1.3.18

Why the committee made the recommendations

Qualitative evidence indicated that multi-agency working and learning can help to improve safeguarding practice. There were issues with this evidence (mainly with the methods used for recruitment and data analysis processes, and the limited adequacy and relevance of the data), but it did align well with the committee's own experience.

The recommendation covering staff apprehensions about external oversight was made because the committee are aware that staff can feel criticised and undermined by people running training (especially people from external agencies). This can undermine the effectiveness of training and learning with other organisations if positive relationships do not already exist.

The committee made a recommendation on sharing information from Safeguarding Adults Boards with care home staff because they thought it could improve accountability and help staff understand the responsibilities of other practitioners and organisations in relation to safeguarding.

How the recommendations might affect practice

In some care homes, staff already have the opportunity to share good practice and challenge poor practice. However, it is not uncommon for staff to work in a climate of suspicion and defensiveness. These recommendations encourage openness about lessons learned across agencies, and emphasise the factors that might help care homes to make their culture more positive.

Managers will need to give staff time for these discussions to take place, and will need time themselves to promote the reflective and transparent approach to safeguarding.

Full details of the evidence and the committee's discussion are in:

- evidence review D: responding to and managing safeguarding concerns in care homes
- evidence review I: embedding organisational learning
- evidence review F: strategic partnership working.

Return to recommendations

Record-keeping

Recommendations 1.3.19 to 1.3.21

Why the committee made the recommendations

Qualitative evidence suggested that recording actions or preventative measures and sharing these with colleagues can help staff to more effectively safeguard residents. Although there were concerns about this evidence (mainly regarding the adequacy and relevance of the data), the committee also drew on their own expertise to make the recommendations. In their experience, the way that safeguarding records are used and reviewed can play a key role in embedding learning and improving safeguarding practice.

How the recommendations might affect practice

Standards of documentation and record keeping within care homes vary widely, so these recommendations are expected to help standardise practice.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning.

Return to recommendations

Indicators of individual abuse and neglect and immediate actions to take if you consider abuse or neglect

Recommendations 1.4.1 to 1.4.20 and 1.5.1

Why the committee made the recommendations

There was no research evidence about the indicators that should alert people to abuse and neglect in care homes. Instead, the committee based these recommendations on a review of existing non-NICE UK health and social care

guidance (see the context and evidence review C for details of the guidance). There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to make recommendations, alongside their own expertise and experience.

Most of the indicators are adapted from the guidance the committee reviewed, and others were added by the committee based on their knowledge and expertise.

The aim of these recommendations is help people better understand when a safeguarding referral should be made and when a referral should not be made. The committee felt that some indicators are more serious or urgent than others. This is because, in their experience, those indicators represented a higher likelihood of abuse and neglect. To reflect this, the indicators are split into 2 categories ('consider' and 'suspect'), with different actions based on the likelihood of abuse or neglect. The 'suspect' indicators need to be reported to a care home safeguarding lead and potentially referred to the local authority for a safeguarding enquiry. The 'consider' indicators would not immediately need to be referred to the local authority.

Some of the indicators of neglect may also be indicators of self-neglect. The guidance the committee reviewed made little mention of this. Based on this lack of coverage the committee felt it was important to make a research recommendation on self-neglect in care homes. They also included a consensus-based recommendation on self-neglect, as they agreed that this issue is especially important because self-neglect in care homes raises questions about the balance between individual choice and the home's duty of care. It also affects the safety, health and wellbeing of other residents, staff and visitors, and can lead to false allegations of abuse and neglect against staff and care homes.

Medication misuse can be a sign of neglect or physical abuse, so the committee included slightly different indicators in both sections.

The committee agreed that indicators of sexual abuse are particularly important because residents may not be able to communicate directly that they are being

sexually abused. Care home staff need to be able to recognise these indicators and act upon them.

All types of abuse involve some level of psychological abuse, and psychological abuse may be a sign that other forms of abuse are also happening. Psychological abuse affects the safety, health and wellbeing of other residents, staff and visitors.

Recommendations on financial and material abuse are needed because, while staff are often experienced at recognising other types of abuse, they may find it more difficult to recognise certain types of financial and material abuse.

Discriminatory abuse is important to highlight because it may be difficult to recognise, and may also involve other types of abuse or neglect. It affects the safety, health and wellbeing of residents, because their care may not meet their needs.

How the recommendations might affect practice

The recommendations are based on existing non-NICE UK guidance, so staff should be familiar with the indicators in this guideline.

Care homes may need to do more to help their staff understand these indicators. But doing so will help care homes manage safeguarding issues more proactively, and deal with early warning signs of potential neglect.

Acting early may help to reduce the number of section 42 enquiries involving the care home, local authority and others. The recommendations may also improve the quality and safety of care and support for residents.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

Immediate actions to take if you suspect abuse or neglect – making sure people are safe

Recommendations 1.6.1 to 1.6.4

Why the committee made the recommendations

No directly relevant research evidence was identified on what to do if abuse or neglect is suspected. Instead, the committee used existing non-NICE UK health and social care guidance on recognising and reporting abuse and neglect in care homes. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work and used it to inform recommendations on:

- ensuring that no one is in immediate danger
- thinking about who needs to be informed or consulted
- keeping the person at risk involved in the safeguarding process.

The existing guidance did not cover all the areas that the committee thought were important, so they also used their own knowledge and expertise when agreeing the recommendations.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

Gathering information

Recommendations 1.6.5 to 1.6.10

Why the committee made the recommendations

There was no research evidence identified on gathering information when abuse or neglect is suspected. Instead, the committee used existing non-NICE UK health and social care guidance about information gathering when abuse or neglect is suspected. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to inform the recommendations, alongside their own expertise and experience. The guidance highlighted the importance of writing down carefully what the person discloses using their own words, but not interviewing them, and encouraging the resident to preserve any physical evidence if a crime may have been committed.

How the recommendations might affect practice

Inconsistent or low-quality records could impact on future enquiries. To ensure staff understand how to gather and record information correctly, care homes and care home providers may need to provide extra training.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

Confidentiality, and discussing and reporting suspected abuse and neglect

Recommendations 1.6.11 to 1.6.13

Why the committee made the recommendations

There was no research evidence identified on confidentiality and suspected abuse and neglect. Instead, the committee used existing non-NICE UK health and social care guidance on recognising and reporting abuse and neglect in care homes. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to inform the recommendations.

When the existing guidance did not cover all the areas the committee thought were important they also used their own expertise and experience to make the recommendations.

The committee used their experience and expertise to make the recommendation on reporting suspected abuse and neglect, and who to contact if the problems are with the management of the care home. The committee felt it was important to be clear that if you suspect abuse and neglect you must tell someone in a responsible and accountable position about this.

How the recommendations might affect practice

There may be uncertainty within care homes around confidentiality, and when to share information. Care homes may need to provide staff with training on the

importance of sharing information and the potential risks of not doing this correctly. There may be an impact on staff time and resources. But this would be outweighed by the benefits of making staff aware of who to share concerns with, which should increase the speed of responses to safeguarding.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

Care home safeguarding leads

Recommendations 1.7.1 to 1.7.5

Why the committee made the recommendations

There was no research evidence identified on safeguarding leads. Instead, the committee reviewed existing non-NICE UK sector guidance on recognising and reporting abuse and neglect in care homes. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to inform the recommendations, alongside their own expertise and experience.

The committee emphasised the importance of asking the resident at risk what they would like to happen next, to ensure that the response to safeguarding was in line with the principles of Making Safeguarding Personal. They also agreed that care homes should build good relationships with local authorities, seeking advice if needed, in order to better judge when referrals should be made.

How the recommendations might affect practice

Care homes will have to check that their safeguarding leads have the relevant skills and competencies to assess and act on concerns. If they do not, training may be needed. Care homes may also have to change the way they work with the local authority, to ensure they have a good relationship and can seek advice and support when needed. The implications for care home resources should not be significant,

and some of the ways of working suggested may already be in place in some or most care homes.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

Local authorities

Recommendations 1.7.6 to 1.7.14

Why the committee made the recommendations

The committee used evidence from a number of sources to make recommendations specifically for local authorities. These included qualitative themes from research evidence on progressing safeguarding concerns and information needs, and existing non-NICE UK health and social care guidance on recognising and reporting abuse and neglect in care homes.

The committee had limited confidence in the qualitative evidence available on this issue. The main issues were:

- relevance – in some studies it was not always clear whether research findings related specifically to care homes
- limited data.

There were also methodological concerns regarding some of the studies, for example in relation to recruitment strategies and data analysis processes.

The committee also reviewed existing health and social care guidance. There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to inform the recommendations. The committee also used their own expertise and experience to make recommendations. In addition, they linked the recommendations to Care Act statutory requirements for local authorities. The committee emphasised what care homes find most important when they make a safeguarding referral to a local authority, and at the beginning of a section 42 enquiry.

The evidence highlighted the value that care homes place on local authorities as a key source of support and transparent advice. To reflect this, the recommendations emphasise how local authorities should work with other organisations and support care homes to promote best practice.

Local authorities also use guidance on section 42 enquiries from the Association of Directors of Adult Social Services and the Local Government Association. This guideline aims to complement these other sources of guidance, rather than duplicate them.

How the recommendations might affect practice

Existing relationships between care homes and local authorities may vary. Depending on how well local authorities already work with other organisations, they may need to do more to develop good ongoing relationships about safeguarding with care homes and to promote multi-agency working. More resources may be needed for a multi-agency approach to safeguarding, but it should improve the quality and safety of care and support.

Details of the evidence and the committee's discussion are in:

- evidence review C: tools to support recognition and reporting of safeguarding concerns
- evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting
- evidence review G: multi-agency working at the operational level in the context of safeguarding.

Return to recommendations

Working with the resident at risk during a safeguarding enquiry

Recommendations 1.8.1 to 1.8.21

Why the committee made the recommendations

The committee used qualitative themes from research evidence on responding to and managing safeguarding concerns in care homes, and support and information needs for everyone involved in safeguarding concerns in care homes.

- The evidence showed that residents benefit when they are involved and kept informed throughout the safeguarding process. The evidence also emphasised the value that residents place on support from family, friends or advocates in helping them achieve their desired outcomes methodological issues, such as recruitment strategies and data analysis processes
- the relevance of the data, as it was not always clear whether findings related specifically to care home settings, and the studies provided only limited data.

The committee therefore also used the Making Safeguarding Personal framework and the Care Act 2014. These sources highlight the importance of involving people fully as possible in decisions and giving them the information and support they need to participate.

The evidence matched the committee's experience of practice. They agreed that involving people in decision making will help them achieve the outcomes they want, and make it more likely that they will receive safe and effective care after the enquiry or investigation ends. Although the committee were able to draw on their own knowledge and experience, they felt that the gap in the evidence indicated that a research recommendation was needed about the views of care home residents in relation to their experiences of safeguarding enquiries. Getting the views of residents will ensure that their needs are understood and that subsequent care can be person-centred and outcomes-focused.

The committee recognised that there should be a clear difference and understanding of the roles of the practitioners and independent advocate involved in safeguarding. Although the practitioner might be acting in the best interest of the person, they may be operating within the constraints of their role. It is only the independent advocate who acts according to instruction from the person.

Residents will often need emotional and practical support while an enquiry is taking place. In addition, they may need this support to continue afterwards, and their needs should be reassessed after the enquiry.

How the recommendations might affect practice

Organisations may need to do more to involve people at risk and their independent advocates in safeguarding enquiries. Implementing the recommendations may involve minor changes to existing practice.

The recommendations could also lead to greater demand for support, for example, for speech and language therapists, from people at risk. This may have cost implications, but access to support is a statutory right under the Care Act 2014 and is part of the Making Safeguarding Personal framework.

There is variation in how support is currently provided. Some organisations will need to review how they provide support. This may have resource implications for care homes, who will be responsible for ensuring that support is available in the short and long term and that it is tailored to each person's needs.

Full details of the evidence and the committee's discussion are in evidence review D: responding to and managing safeguarding concerns in care homes and evidence review E: what are the perceived support and information needs for all involved when a safeguarding concern is raised within a care home setting.

Return to recommendations

Supporting staff who are under investigation

Recommendations 1.9.1 to 1.9.6

Why the committee made the recommendations

A small amount of qualitative evidence provided findings relating to the information and support that care home staff need during safeguarding enquiries. However, there were concerns with the adequacy of this data, limitations arising from the data analysis processes used in the studies, and issues with selection bias.

Despite the limitations of the evidence, the committee recognised that this is a crucial issue, in particular for staff who are under investigation. The committee used their own expertise to support the evidence and make recommendations.

The recommendations should reduce the potential psychological and emotional distress on affected staff. They should also encourage staff to report safeguarding problems in the future, as it would be clear to them that everyone would receive support regardless of their involvement.

How the recommendations might affect practice

Some care home providers already fund access to employee assistance programmes, so would not significantly need to change practice. There could be cost implications for care home providers that do not have employee assistance programmes, unless alternative programmes or funding are available for staff already. The committee did not believe that holding return-to-work meetings would be a substantial change in practice. These meetings already commonly occur, so they may just need more emphasis on guidance and support for the affected member of staff.

Care homes do not currently nominate people to provide independent support to staff accused of abuse or neglect. However, as this can be an existing member of staff, the committee were confident that there would be no significant resource impact.

Full details of the evidence and the committee's discussion are in evidence review E: support and information needs.

Return to recommendations

Supporting care home staff

Recommendations 1.9.7 to 1.9.11

Why the committee made the recommendations

There was a small amount of qualitative evidence relating to the information and support needs of care home staff during a safeguarding investigation. There were concerns around the adequacy of the data, issues with the methods used to analyse the data, and problems with how the study authors addressed potential bias. Despite these limitations, the committee agreed on the importance of support

for care home staff, and built on the evidence with their own expertise. These recommendations are important because:

- managers have a key role in helping staff obtain support and advice
- care homes need to have a more honest and open culture when it comes to potential safeguarding issues
- quality of care can be undermined when staff who raise safeguarding concerns are treated negatively, or when staff are afraid to work with residents who have raised or been involved in safeguarding concerns.

How the recommendations might affect practice

During a safeguarding enquiry or investigation, care home managers will need to allocate time to hold discussions with staff and direct them to external information and advice. Managers will also need time to provide one-on-one support to anxious staff, and to make changes to policies, processes and training in response to the outcome of safeguarding enquiries.

In many care homes, managers already do all of this. However, in care homes where this is not the case, managers will need to spend more supporting staff and learning from safeguarding enquiries.

Full details of the evidence and the committee's discussion are in evidence review E: support and information.

Return to recommendations

How local authorities should support care homes during an enquiry

Recommendations 1.10.1 to 1.10.5

Why the committee made the recommendations

There was a small amount of qualitative evidence about the impact of safeguarding enquiries on care homes and the support that care homes, managers and staff need. There were concerns regarding the adequacy and relevance of the data, as it was not clear whether all of the findings were from a care home context. The committee built on this evidence with their own expertise.

The committee made these recommendations because the business impact of safeguarding enquiries is often overlooked, but can be detrimental to care homes. There can be a financial impact, as well as problems with recruitment and retention of staff. The recommendations should help reduce these risks. In addition, improved information sharing and trust between care homes and local authorities will help to reduce the stress of the enquiry process.

How the recommendations might affect practice

Local authorities will need to identify a single point of contact for care homes, which in some cases will be a change in practice. Local authorities may also need to learn more about the reputational risks to care homes as well as effects on staff morale when they are involved in safeguarding enquiries. Finally, local authorities will need to offer feedback and practical support to care homes.

Full details of the evidence and the committee's discussion are in evidence review E: support and information needs.

Return to recommendations

Meetings during a safeguarding enquiry

Recommendations 1.11.1 to 1.11.3

Why the committee made the recommendations

There was a small amount of qualitative evidence on effective multi-agency working, and on responding to and managing safeguarding concerns. This evidence had various problems:

- issues with the methods used in the studies, such as the way they addressed bias and ethical issues, and their recruitment strategies
- the adequacy of the findings, as the studies provided only limited data
- the relevance of the evidence, as the studies presented findings from domiciliary settings and it was not always clear when findings related specifically to the care home context.

However, the committee recognised the importance of these issues and were able to build on this evidence using their own expertise.

The evidence suggested that some people felt excluded from important safeguarding meetings. While this is sometimes justifiable, the committee wanted to reduce suspicion about possible bias and increase transparency and collaboration by ensuring that people are always given an explanation and a chance to contribute in another way.

Safeguarding meetings should be opportunities for different organisations to share information and discuss the needs of adults at risk. Because of the multiple organisations involved and the complexity of the process, communication is important, so the committee made recommendations to ensure that everyone involved is kept informed about the process.

No evidence was identified on the management of safeguarding concerns. Because of the lack of evidence, and the potential variation in practice across the country, the committee made a research recommendation on the effectiveness and cost-effectiveness of the different approaches to investigating safeguarding concerns.

How the recommendations might affect practice

When it comes to safeguarding enquiries, there is wide variation in communication and how clear it is what the outcomes are. These recommendations should lead to greater consistency and higher standards, by ensuring that everyone affected by the safeguarding enquiry is kept informed.

The recommendations do not require specific additional resources, but the chairs of meetings may need to take greater care in their documentation and communication.

Full details of the evidence and the committee's discussion are in evidence review D: responding to and managing safeguarding concerns and evidence review G: multi-agency working.

Return to recommendations

Indicators of organisational abuse and neglect

Recommendations 1.12.1 to 1.12.12

Why the committee made the recommendations

No research evidence was identified about the indicators that should alert people to organisational abuse and neglect in care homes. Instead, the committee based these recommendations on a review of non-NICE UK health and social care guidance, (see evidence review C for details of this guidance). There were uncertainties around the methods used to develop much of this guidance. However, the committee found the guidance to be highly relevant as a source of evidence to support their work, and used it to make recommendations, alongside their own expertise and experience.

Most of the indicators are based on a synthesis of findings from the review of health and social care guidance documents, and others were agreed by the committee based on their experiential knowledge.

The aim of these recommendations is help people better understand when a safeguarding referral should be made and when a referral should not be made. The committee felt that some indicators would warrant more urgent or more significant action than others. This is because, in their experience, those indicators represented a higher likelihood of organisational abuse and neglect. To reflect this, the indicators are split into 2 categories ('consider' and 'suspect'), with different actions based on the likelihood of abuse or neglect. The committee particularly wanted to emphasise the key role of local authorities in relation to organisational abuse or neglect both in their proactive role, monitoring care standards locally and in initiating and overseeing Section 42 enquiries, including large scale enquiries when these are needed.

The committee agreed, based on their own expertise and experience, that local authorities needed to plan ahead for the support that might be needed for the wide range of individuals and groups of people involved in enquiries into organisational abuse and neglect. This would be especially true of large-scale enquiries. This is so that the support is in place at the right time while the enquiry is underway.

Organisational abuse is distinct from other types of abuse or neglect because it is generally not directly caused by individual action or inaction, instead it is more likely to be a cumulative consequence of how services are managed, led and funded.

Abuse and neglect are more likely to happen when staff are poorly trained, poorly supervised, unsupported by management, and when the care home has a culture that does not promote openness and good communications. Therefore, the committee made recommendations focusing on these issues.

Organisational abuse and neglect both involve some level of psychological or medical and physical abuse, and may be a sign that other types of abuse and neglect are also happening.

How the recommendations might affect practice

The recommendations are based on a review of existing guidance, so staff should be familiar with the indicators referred to in this guideline.

Care homes may need to do more to help staff, residents and visitors understand these indicators. However, doing so will help care homes manage safeguarding issues more proactively, and deal with early warning signs of potential organisational abuse and neglect. Acting early may help to reduce the number of safeguarding section 42 enquiries involving the care home. The recommendations may also improve the safety and quality of care and support for care home staff, residents and visitors.

Care homes may also need to change their recruitment processes, to ensure that applicants are suitable and have been properly vetted.

Staff may also need more training and support, to ensure that they understand their duty of care and to improve their confidence in identifying and reporting potential organisational abuse and neglect.

Identifying organisational abuse and neglect is likely to have other benefits for the care home, in reducing staff turnover and staff absences. This should in turn improve the safety, health and wellbeing of care home residents.

Full details of the evidence and the committee's discussion are in evidence review C: tools to support recognition and reporting of safeguarding concerns.

Return to recommendations

How care homes should learn from safeguarding concerns, referrals and enquiries

Recommendations 1.13.1 to 1.13.2

Why the committee made the recommendations

Although evidence on implementing learning in care homes was available, this did not focus specifically on using findings from past safeguarding referrals and enquiries in the care home. However, the committee agreed that these findings can be a key source of learning material, and they regularly use information from Safeguarding Adults Reviews in their own work. As a result, they felt that it was important to make specific recommendations on this, to ensure that this learning is more widely promoted. The recommendations are for care home managers and local agencies, to ensure that organisations can implement this at the local level.

Given the limited evidence about the use of Safeguarding Adults Reviews, the committee made a research recommendation to identify how the findings from these reviews affect practice in care homes. This includes:

- staff experiences in using findings from these reviews
- the views of Safeguarding Adults Boards and commissioners on how care homes have learned from Safeguarding Adults Reviews
- the barriers and facilitators to embedding learning from Safeguarding Adults Reviews in care homes.

The committee agreed that this research is important to identify how care homes understand Safeguarding Adults Reviews and what they learn from them. If the research allows care homes to better utilise these reviews to improve practice, the safety and wellbeing of care home residents will improve.

How the recommendations might affect practice

Managers may need to dedicate time specifically to collating data and sharing findings with staff. However, this is unlikely to take a significant amount of time, as there should already be systems in place to record and share this information.

Full details of the evidence and the committee's discussion are in evidence review I: embedding organisational learning about safeguarding.

Return to recommendations

Finding more information and committee details

To find out what NICE has said on topics related to this guideline, see our web page on adult social care.

For details of the guideline committee see the committee member list.