West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

# West Dunbartonshire Community Health and Care Partnership

# Protocol for Large Scale Investigations of Adults at Risk of Harm

2014

This protocol was developed by a short life working group, the membership of this group was as follows:-

- Adrian McBride – IOM[1], Learning Disability, HSCP[2] (Chair)
- Caroline Doherty – Adult Protection Co-ordinator, HSCP
- Helen Faye – Senior Social Worker, Older Adults, HSCP
- Brian Gardiner – Contracts and Commissioning Officer, HSCP
- Graham Cordner – Detective Inspector, Police Scotland
- Val McIver – Clinical Nurse Manager , HSCP
- Wilma Morgan – Team Manager, Adults, Care Inspector
- Trisha McCoy – Service Manager, Cornerstone
- Patricia Halkett – Reviewing Officer, HSCP
- Kate Kerr – Quality and Service Development Manager for Older People Services, HSCP

[1] Integrated Operations Manager
[2] Health and Social Care Partnership

# Protocol for Large Scale Investigations of Adults at Risk of Harm

## 1. DEFINITION

**Definition of a Large Scale Investigation**
A Large Scale Investigation is a multi-agency response to circumstances where there may be two or more adults at risk of harm within a care service (this includes residential care, day care, home based care or a healthcare setting). The Chief Social Work Officer or Director will be alerted to all large scale investigations at the earliest opportunity.

### 1.1 Purpose of Procedure

This procedure has been created to:

- Provide a standardised approach to carrying out a Large Scale Investigation for all professions consistent with current evidence of best practice.
- Offer a framework for an alternative process to holding large numbers of individual Adult Support and Protection Inquiries and ensure that there is an appropriate overview / co-ordination where a number of agencies have key roles to play.
- Facilitate a shared understanding of the purpose of the protocol among all staff working in West Dunbartonshire Community Health and Care Partnership (HSCP), Police Scotland and the Care Inspectorate.
- Clarify partner agencies' responsibilities in relation to Large Scale Investigations in West Dunbartonshire.

### 1.2 Scope

This procedure applies to all adults at risk of harm, as defined by the Adult Support and Protection (Scotland) Act 2007, in regulated care service within the West Dunbartonshire area.

### 1.3 Relevant Legislation

The following legislation is viewed as being relevant and/or related to this procedure:

Adult Support and Protection (Scotland) Act 2007
Adults with Incapacity (Scotland) Act 2000
The Mental Health (Care and Treatment) (Scotland) Act 2003
The Social Work (Scotland) Act 1968, section 12, section 6
Human Rights Legislation
Regulation of Care (Scotland) Act 2001
Criminal Procedures (Scotland) Act 1995
Public Services Reform (Scotland) Act 2010

### 1.4 Relevant Procedures

The following agency/interagency procedures are viewed as being relevant and or related to this document:

- Adult Support and Protection Procedures 2012
- The Care Inspectorate's Adult Support and Protection Policy and Procedure
- OPG[3]'s Adult Support and Protection Policy and Procedure
- MWC[4]'s Adult Support and Protection Policy and Procedure
- Health Improvement Scotland Adult Protection Policy and Procedure
- Council contracting agreements.
- SSSC[5] code of practice
- Nursing and Midwifery Council code of practice

## 2. INTRODUCTION

2.1 The Adult Support & Protection (Scotland) Act 2007 (The Act) introduced a duty for councils to make inquiries where it is known or believed that an adult may be at risk of harm and where protective action may be required. The Act gives the Council the lead role in Adult Protection investigations and makes no distinction between NHS premises and other settings.

2.2 This procedure has been agreed by West Dunbartonshire Council HSCP, Police Scotland and the Care Inspectorate, which will be the key agencies involved in any investigation process involving regulated and managed care services. It is designed to minimise risk to individuals who receive a health or care service. Managers of service providers will have their own disciplinary procedures for staff within their organisations.

Due to its statutory responsibilities for regulated care services, the Care Inspectorate and Police Scotland participated in the development of this procedure. Whilst not directly involved in the creation of this procedure; Healthcare Improvement Scotland (HIS), Office of the Public Guardian and the Mental Welfare Commission have also been consulted in relation to the content.

[3] Office of the Public Guardian
[4] Mental Welfare Commission for Scotland
[5] Scottish Social Services Council

## 3. IDENTIFICATION OF HARM

3.1 Concerns about an adult at risk being harmed in a care setting can be raised from many sources including:

- Family / friends making a complaint about standards of care
- Whistleblowing within an organisation
- Procurator Fiscal investigating a death
- Concerns raised from an admission to hospital
- Concerns raised after discharge from hospital
- Concerns highlighted via regulatory process

3.2 A Large Scale Investigationshould be considered if one or more of the following applies:

- When an adult protection referral is made that involves 2 or more adults in the same service.
- Where a number of harmers are suspected.
- Where institutional harm is suspected.
- Where there has been 3 or more adult protection Inquiries within a 6-month period related to the same service where the outcome indicates that serious harm has been caused.
- Where a whistle-blower makes allegations about the service.
- Where the situation is very complex and where special planning and coordination of the investigation is required.
- Where an investigation into one allegation leads people to strongly believe other people may also be victims of the same harm.
- Where there are significant concerns about the quality of care provided and there are concerns about the services ability to improve.

See Appendix A for examples of above.

## 4. LARGE SCALE INQUIRY MEETING

4.1 When there is a concern or evidence that an adult is at risk of being harmed within a care service consideration should be given as to whether there is potential that other adults are also experiencing harm or are at risk of harm. If this is the case, a Large Scale Inquiry Meeting should be convened within 5 working days, chaired by appropriate Head of Service, HSCP Lead Officer for Adult Protection or HSCP Chief Social Work Officer, but if unavailable the chair should be devolved down to appropriate Integrated Operations Manager and an outcome may be that a Large Scale Investigation will be recommended. In this circumstance, this protocol should be followed. The Chairperson of the Large Scale Inquiry Meeting will use the set agenda contained within this procedure (see Appendix B) to frame the discussion.

4.2 If it is unclear if the criteria for a Large Scale Investigation has been met, the matter must be referred to appropriate Head of Service or an Investigation meeting must be convened, to determine the risk of harm.

4.3 At this stage of the process, relevant notifications to other appropriate agencies (who are not presently aware of the concerns) should be made.

4.4 The agencies who may be notified include [please note this is not an exhaustive list]:

- The Care Inspectorate (for concerns relating to registered care settings)
- Police Scotland (for concerns where there is potential criminality)
- The Mental Welfare Commission (where the concerns relates to ill treatment, neglect or cruelty towards a person with a mental disorder)
- Healthcare Improvement Scotland (for concerns located within NHS care settings)
- HSCP Contracts/Commissioning Team
- The Office of the Public Guardian

4.5 Following the meeting, any actions that are required to safeguard adults at immediate risk should be taken straight away and should not wait for further stages in the procedure. This reflects the position of the HSCP Adult Support and Protection Procedures 2012 which is clear that if an adult at risk is in immediate danger, action should be taken without delay to safeguard/protect that individual.

**4.6 It is important that all decisions taken should be recorded**.

4.7 A caveat to point 4.4 is that if there is the potential for a criminal investigation as a result of the concerns raised, Police Scotland will give instruction/advice as to what actions/activities can or cannot be progressed. The general principle is that any criminal investigation must take primacy and not be compromised by other agencies' actions. However, this will always be balanced against the need for timely action to ensure the safety of any adults who are potentially at risk.

4.8 If the degree of concern is high then it may be more appropriate to proceed straight on to 'Large Scale Planning Meeting' stage detailed below.

## 5. LARGE SCALE INVESTIGATION PLANNING MEETING

5.1 A Multi-Agency planning meeting, chaired by appropriate Head of Service, Chief Social Work Officer or HSCP Lead Officer for Adult Protection but if unavailable the chair should be devolved down to the appropriate Integrated Operations Manager who will have overall responsibility for arranging and conducting the meeting and should be convened as soon as possible but no later than 5 working days. The people attending should be of sufficient

seniority to contribute to decision-making and resource allocation if necessary.

5.2 An Integrated Operational Manager for the specific client group may be the chairperson unless the concern is focussed on one of their own services. In this case, the Integrated Operational Manager can be invited to sit in on the meeting but an alternative chairperson needs to be identified by HSCP Lead Officer for Adult Protection or appropriate Head of Service.

5.3 Attendees of this meeting will be referred to as the 'Large Scale Investigation Group'. As a minimum a representative from the local authority legal section, police and HSCP should be represented and the Care Inspectorate or Scottish Fire and Rescue where appropriate.

5.4 It is important to involve the relevant senior manager of the managed care setting in the potential investigation throughout the process, where possible. However, there will be instances where notifying the managed care setting may not be appropriate, for example, due to risk of compromise to an investigation. A decision as to whether to exclude a representative from the managed care setting from the planning meeting will be taken by the Chairperson in consultation with relevant partners e.g. Police Scotland, Care Inspectorate or Director/Head of Service.

5.5 The Chairperson of the Large Scale Investigation Planning meeting will use the set agenda contained within this procedure (see Appendix C) to frame the discussion.

5.6 Any staffing/resource issues which may impede the progression of an investigation should be escalated to senior management within the relevant body for quick resolution

5.7 The Large Scale Investigation Group meeting will be minuted and a copy sent to all participants and those who were invited but were unable to attend. Minutes will also be sent to the Chief Social Work Officer for information and will be circulated within 7 days of the meeting being held.

5.8 Where the concerns relate to potential criminal activity the meeting will ensure that:

- Any agreed action plan will focus on the immediate protective measures required, but that;
- The action plan will otherwise be primarily informed by the requirements of the Police to conduct a criminal investigation in liaison with the Procurator Fiscal.

## 6. LARGE SCALE INVESTIGATION

6.1 The Large Scale Investigation Group's first step when proceeding with an investigation is the appointment of a team led by a Council Officer, who should be a Senior Social Worker or Manager. This officer will be an authorised Council Officer under the Adult Support and Protection (Scotland) Act 2007 and possess substantial adult protection fieldwork experience. The role of the Lead Council Officer will be to plan and supervise all investigation activity. It is expected that the lead Council Officer will provide regular updates on the progress of the investigation to all relevant parties. It should be stressed that there is no expectation on the Lead Council Officer to undertake the investigatory work alone.

It is important that within any Large Scale Investigation focussing on a HSCP managed service that Council Officers from the service or client section should not be involved. Council Officers from other sections within the HSCP will undertake the Investigation. This will prevent any suggestion of a possible conflict of interest if the findings are challenged.

6.2 If the identified risks, to a number of adults, relate to the actions of a staff member (or staff members) within an organisation, then that organisation will be responsible for invoking its own disciplinary proceedings and ensuring that any immediate risks are removed or minimised. They will be required to inform the Large Scale Investigation group of the action taken.

6.3 The investigation should be carried out as sensitively as possible. The impact on the adults should always be considered and the adults' wishes must be taken into account. A balance must be reached between the need to protect the adults and respecting their rights.

6.4 The investigation should be undertaken as soon as possible, taking into account the impact on the adults in the managed care setting.

6.5 If there is a criminal investigation this will take priority over any disciplinary proceedings and the organisation should be advised accordingly. Where the organisation concerned contracts with the HSCP to provide a service, then the appropriate Contracts Officer / Quality Assurance Section should be advised of any indications that the provider may be in breach of contract.

6.6 It is to be noted that there is a duty under the Act to consider the importance of advocacy. Service users, or their primary carer/nearest relative, should be given information about an appropriate advocacy service in all cases.

6.7 Obtaining consent from an adult(s), for sharing information and/or passing on concerns (to the police for example) is a key issue. Where an adult does not give consent consideration will need to be given to:

- The possibility that they may be experiencing undue pressure,
- The risks to which other adults may be exposed by not sharing information,
- The adult's capacity at the time to make informed decisions,
- Urgency of situation.

6.8 Ensuring consent for medical examination is the responsibility of the examining medical officer.

6.9 Different situations will necessitate different levels of investigatory response. For example, in a situation where there have been concerns about standards of care within a registered care setting over a period of time, the majority of information may already be available and the primary responsibility of the Lead Council Officer will be to address any gaps in knowledge and ensure collation of all known reports. Conversely, in situations where the allegation of harm is completely new to the statutory services, far more substantial direct investigation may be required – potentially including interviews with service users, staff, family members etc.

6.10 Those involved in the investigation should always meet beforehand, to discuss how to proceed, making sure that they are aware of all the facts to date, any background knowledge/information regarding the adults involved and any alleged perpetrator.

6.11 Once the investigatory process is concluded, the Lead Council Officer will be responsible for collating the information obtained ready for presentation to, and consideration at the Adult Protection Large Scale Investigation Outcome Meeting. This meeting is to be completed within 15 working days from the referral.

6.12 It is important that the Chief Social Work Officer, HSCP Lead Officer for Adult Protection and the Chairperson of the Adult Support and Protection Committee are informed of the outcomes.

6.13 The Large Scale Investigation Group should also consider the impact the Large Scale Investigation will have. This will include consideration of and contingencies for:

- How the service will be managed in the interim,
- Impact on service users, families and staff as a result of press interest,
- Processes undertaken in the review of service users / patients,
- How information should be disseminated to provide reassurance and
- Removal of clients/relatives.

## 7. MEDIA STRATEGY

7.1 Where media interest is likely, the Chairperson of the Large Scale Investigation Group and the appropriate communication officers from the relevant agencies should refer to West Dunbartonshire Media Relations Protocol. Detail of this can be found at http://newintranet.west-dunbarton.gov.uk/EasySiteWeb/GatewayLink.aspx?alId=81550

7.2 HSCP Adult Protection Co-ordinator should inform the Chair of the Adult Protection Committee and HSCP Lead Officer for Adult Protection of any Large Scale Investigations as the media may contact them.

## 8. LARGE SCALE INVESTIGATION OUTCOME MEETING

8.1 Following conclusion of the Large Scale Investigation, the Lead Council Officer will provide the Large Scale Investigation Group Chairperson with a report of any completed investigation in writing.

8.2 The Chairperson of Large Scale Investigation Group will convene an Outcome Meeting to allow for discussion/deliberation of the findings.

8.3 It would be considered good practice for the Chairperson of the Outcome Meeting to be the same person who chaired the original planning or Investigation meeting.

8.4 All those who were invited to the original planning meeting should also be invited to the outcome meeting. In addition, any other relevant parties who may contribute to effective decision making should also be invited.

8.5 Representatives of the management of the managed care setting should normally be invited to attend the outcome meeting. Due to the nature of the discussions/deliberations, the staff of the managed care setting may be excluded from sections of the outcome meeting proceedings – this will be at the discretion of the Chairperson.

8.6 The Chairperson of the Outcome Meeting will use the set agenda contained within this procedure (see Appendix D) to frame the deliberations.

8.7 Overall, the purpose of the Large Scale Investigation Outcome Meeting will be to:

- Consider the reports from the Lead Council Officer, Police, Care Inspectorate and any other relevant information.
- Ensure appropriate risk assessments have been completed and welfare / protection plans are in place
- Ensure that timescales are set for following up any outstanding concerns

- Determine, based on the information obtained during the investigation and thereafter, if the service users within the managed care setting are 'adults at risk of harm' under the terms of the 2007 legislation.
- Develop an appropriate action plan to address the concerns/risks.

8.8 By the end of the Large Scale Investigation Outcome Meeting, a decision should be reached as to the on-going management of the concerns. This will result in one of the following outcomes:

- No Further Action: this outcome would be selected if the service users within the managed care setting were no longer found to be at risk of harm.
- Adult Protection Action Plan: this outcome would be selected if the service users within the managed care setting remained at risk of harm. This plan will include actions to safeguard all individuals involved, either collectively or on an individual basis.
- Quality Assurance Action Plan: this outcome would be selected when there are quality assurance concerns rather than Adult Protection concerns.

8.9 The action plan should be specific; it should clearly identify tasks, roles, responsibilities and timescales.

8.10 In addition, if an action plan has been agreed, then a date for review of the plan must be set at the outcome meeting. This review would use the same agenda and procedures as the first review meeting.

8.11 The minutes of the large scale investigation outcome or review meeting will be circulated within 7days of the meeting being held.

8.12 If the Large Scale Investigation process ends at this point, the Chairperson may wish to consider whether a review of the work undertaken is necessary to ensure any learning for the future is taken forward.

8.13 The outcomes from Large Scale Investigations may have significant implications that may require policy and practice changes. It is important to identify these and establish an action plan where appropriate.

## 9. ADULT PROTECTION COMMITTEE

9.1 The Lead Council Officer will keep a detailed record of the investigation as a whole, as well as recording in individual Care First records. They should liaise with the Adult Protection Co-ordinator so that there is an overview of the investigation available to the Chair of the Adult Protection Committee, Chief Social Work Officer and HSCP Lead Officer for Adult Protection.

## 10. CONCLUSION OF INVESTIGATION PROCESS

10.1 The Chair should provide the Large Scale Investigation planning or Investigation group Chairperson with details of any completed investigation and ensure that those invited to the Initial Large Scale Investigation Meeting, and the local manager of the Care Inspectorate (if the investigation concerned a registered service), are advised of the outcome in writing.

10.2 Any Large Scale Investigation activity will be reviewed alongside the Large Scale Investigation Protocols. This will allow for evaluation and any activity follow up to be initiated.

**APPENDIX A**

Examples for Identification of Harm concerns:

- **When an adult protection referral is made that involves 2 or more adults.** More than one adult at risk has been potentially maltreated or neglected and as a result experienced significant harm – e.g. one care worker intimidates or threatens more than one adult with learning disabilities in a supported living environment resulting in them being frightened and scared.

- **Where a number of alleged perpetrators are suspected.** More than one person work together to maltreat or neglect adult/s at risk – two or more carers/PA's work together to financially abuse adults living in their own home.

- **Where institutional harm is suspected**. Potential or actual harm due to poor or inadequate care or support or systematic poor practice that affects the whole care setting – Residents must go to bed before night staff come on duty, cannot get food or drink during the night, call bells are taken off people and residents are left all night in soiled beds or pads resulting in a loss of dignity and experiencing degrading practices.

- **Where there has been 3 or more adult protection investigations within a 6-month period related to the same service where the outcome indicates that serious harm has been caused**. Financial harm investigated in January, Medication errors resulting in harm investigated in April and missed calls resulting in serious harm referred in September – all the same agency but different service users. All significant areas of concern signifying the agency is not operating a safe service with continuous improvement.

- **Where a whistle-blower makes allegations about the service.** A whistle-blower alleges the manager of a service instructs staff to water down the milk, use out of date food, portions of food are insufficient–and intimidate or threaten them with the sack if they tell anyone else. Staff often bring in extra food for residents who complain they are hungry.

- **Where the situation is very complex and where special planning and coordination of the investigation is required.** The investigation will require input from a number of agencies and people such as medicines management, tissue viability, health and safety, Care Inspectorate, Police.

- **Where an investigation into one allegation leads people to strongly believe other people may also be victims of the same harm.** An adult complains of being hungry because there is no food. A visit to the home identifies inadequate food, lack of staff availability or it could be a complaint about inadequate heating, broken equipment that could result in harm e.g. hoists or hand rails broken. Degrading practice towards residents is established.

- **Where there are significant concerns about the quality of care provided and there are concerns about the services ability to improve.** High number of low level concerns and complaints are being raised from various people and agencies, there is no registered manager, high staff turnover and generally the environment is poor and service users look neglected and uncared for. Previous involvement with the service indicates the home does not improve quickly enough or is able to sustain improvements. Poor care inspectorate grades may also indicate concerns.

**APPENDIX B**

**Large Scale Inquiry Meeting**

**Agenda**

1. Introductions & Apologies
2. Background Information re: Service
3. Allegations/Concerns
4. Evidence of Risk & Three Point Test

   *The Act defines an 'adult at risk' as a person aged 16 years or over who:*

   - *is unable to safeguard her / his own well-being, property, rights or other interests; and*
   - *is at risk of harm; and*
   - *because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.*

5. Any immediate actions that need to happen to safeguard service users
6. Consider any notification requirements to other agencies/organisations
7. Decisions/Timescales

**APPENDIX C**

**Large Scale Investigation Planning Meeting**

**Agenda**

1. Introductions and apologies.

2. Recording arrangements.

3. Information currently available from each agency and any reports received.

4. Summary of concerns and current situation.

5. Decide if service users qualify as'adults at risk of harm'.

   *The Act defines an 'adult at risk' as a person aged 16 years or over who:*

   - *is unable to safeguard her / his own well-being, property, rights or other interests; and*
   - *is at risk of harm; and*
   - *because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.*

6. Is a large scale investigation required?

   *A large scale investigation will normally be appropriate in situations where multiple service users are considered to be adults at risk of harm due to the same source of concerns.*

7. Investigation planning

8. Any immediate actions that need to occur to safeguard service users

9. Consider any notification requirements to other agencies/organisations

**APPENDIX D**

**Large Scale Investigation Outcome Meeting**

**Agenda**

1. Introduction and apologies

2. Purpose of outcome meeting

3. Discussion of findings from the investigation plus any additional reports received.

4. Clarify if the adults are at risk of harm-note any dissenting views.

   *The Act defines an 'adult at risk' as a person aged 16 years or over who:*

   - *is unable to safeguard her / his own well-being, property, rights or other interests; and*
   - *is at risk of harm; and*
   - *because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected.*

5. Consideration of actions required to protect the adults including application for adult protection orders or other legislation - note any dissenting views.

6. Adult protection plan agreed (include timescales and responsible officers)

7. Review of Adult Protection Plan

   *Tasks set at last meeting should be explicitly reviewed. What is working well? Or not so well? Are there any particular gaps? Any required changes or additions should be discussed and agreed here.*

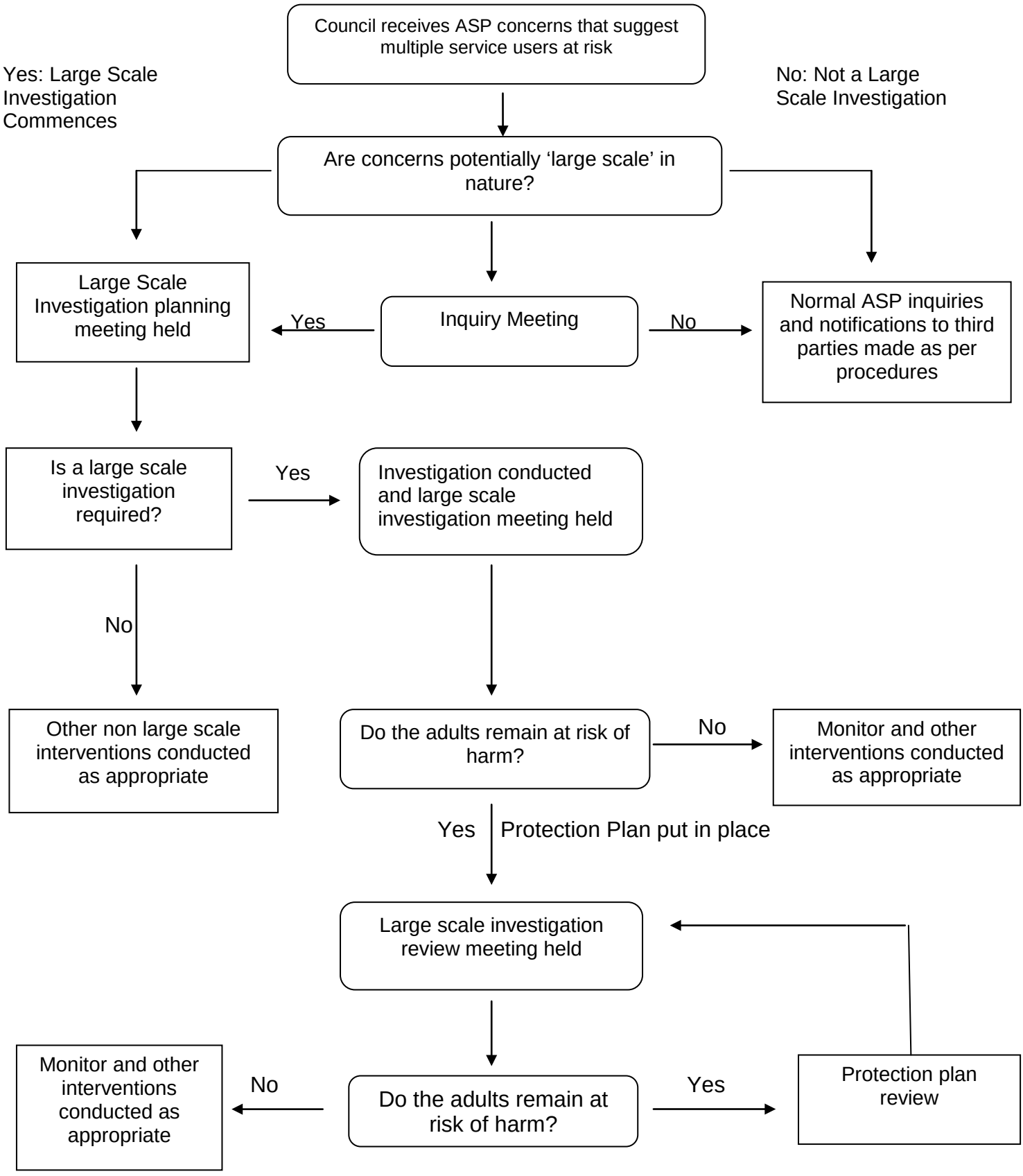
8. Arrangements for Monitoring/ Review

   *(Either specify review date, with reasons, or that review will revert to normal procedures as no ongoing risk/ risk is managed acceptably)*

9. Review arrangements

## APPENDIX E: PROCESS FLOWCHART

NOTE: The flowchart on the following page is designed to provide a simple graphical representation of the large scale investigation process. It cannot cover all possible eventualities, and staff are advised to consult the whole procedure rather than rely on the diagram alone.


Council receives ASP concerns that suggest multiple service users at risk
Yes: Large Scale Investigation Commences
No: Not a Large Scale Investigation
Are concerns potentially 'large scale' in nature?
Large Scale Investigation planning meeting held
Yes
Inquiry Meeting
No
Normal ASP inquiries and notifications to third parties made as per procedures
Is a large scale investigation required?
Yes
Investigation conducted and large scale investigation meeting held
No
Other non large scale interventions conducted as appropriate
Do the adults remain at risk of harm?
No
Monitor and other interventions conducted as appropriate
Yes
Protection Plan put in place
Large scale investigation review meeting held
Monitor and other interventions conducted as appropriate
No
Do the adults remain at risk of harm?
Yes
Protection plan review

**Appendix F: Notification Guide**

| | | |
|---|---|---|
| The concerns relate to a registered service? | → | Contact Care Inspectorate and WDC Quality Assurance. |
| Are the alleged perpetrators registered with a professional body? | → | Notify relevant body i.e SSSC, NMC, GMC, Allied Health Professions. |
| Are the alleged perpetrators registered with Disclosure Scotland? N.B If the staff member has been dismissed then you must notify Disclosure Scotland. | → | Notify Disclosure Scotland if staff member was dismissed. |
| Does the service user have a mental disorder or lack capacity? | → | Contact Mental Welfare Commission. |
| Does the client have a Continuing Power of Attorney or Financial Guardianship in place and lack capacity? | → | Notify Office of the Public Guardian. |

**Appendix G**

# Monitoring Group

# Process and Forms

**Quality in Care Working Group Protocol**

Objectives

By adopting and applying the underlying principles of GIRFEC to "The Quality in Care" model, a multi-agency working group has been formed. To ensure the quality assurance of practice and improving the standards of care for adults receiving care in the community or for adults who live in 24 hour care.

**The key objectives are:**

- To ensure a more co-ordinated and pro-active in the delivery of care
- To share information in relation to the standards and the delivery of care
- Identifying any concerns that may impact on the standards of care.
- Pro-actively improving the standards of care
- Minimising identifiable risks.

Participants

- Head of Service/Lead Officer for Adult Protection
- IOM or SSW Learning Disabilities
- IOM or SSW Older Adult
- IOM or SSW Mental Health
- Reviewing Officer
- Quality and Service Development Manager Care Home, Day Care and Respite Services for Older People
- Quality Assurance Manager
- Contacts and Commissioning Officer
- Adult Protection Co-ordinator
- Older Adults Mental Health Social Worker
- Clinical Nurse Manager
- Consultant Psychiatrist
- Care Inspectorate
- Minute Taker

**Information Requested from**:

Multi-agency partners to provide feedback detailing any concerns noted through their contact with Community Services, hospitals, residential and nursing care homes.

If representatives are unable to attend a written report must be submitted.

**Actions taken prior to Meeting**

Prior to the meeting, all agencies must confirm attendance at least three weeks in advance. Following this, items for the agenda will be requested two weeks before the meeting. Reports will be circulated 5 working days prior to the meeting, along with the agenda, the risk indicator and previous minutes. Information will be distributed to all agencies within 48 hours.

Any reports from multi-agency partners must be submitted 5 working days prior to the meeting. The cut-off point for submitting reports to be considered is 5pm on the Thursday of the week preceding the meeting.

**Reports are confidential / restricted information and, if they are printed, should be kept in accordance with Agency Policies.**

**Discussion of Reports/Information**

- What concerns are identified?
- What risks are identified?
- Where there is shared information in regard to concerns/risks
- Where there are known risks which are being managed within a risk management plan.
- Which agency would be best to provide relevant supports/services to address the identified risks?
- Which agency is taking the lead role? (e.g. NHS Greater Glasgow and Clyde / Care Inspectorate/G.P/ Nursing)
- Does the risk indicator and/or information shared substantiate the need for ; *Police referral and/or Professionals Meeting, Multi- Agency Strategy Meeting.*

**Decisions which can be made are:**

- *Appropriate action already taken*
- *More information required.* Agency identified to do this and make the decision about whether further action is required. Do not necessarily have to bring back to next meeting unless this is specified.
- *Referral via the contact centre - Flow chart.* The agency should be prepared to accept the referral and identify a lead worker. An agency could also be given the task of referring to another agency, e.g. Health/Care Inspectorate.
- *Immediate referral for Interagency Referral Discussion.* Where information has been shared which makes the group thing that a criminal act has occurred.
- Visit by agency or agencies for further assessment or action.

**Referral to Regulatory Body**

Where there may be issues in regard to the practice/professional conduct in relation a staff member who is thought to be a member of a registered body the group should ensure that employers are making a referral to the relevant body as appropriate.

**Recording Decisions.**

Admin will record agreed actions on the agenda list which will be maintained by Adult Protection Team.

The list, with completed tasks / actions will be typed by admin and distributed 48 hrs after the meeting. If participants do not agree with the minute, they should submit a written statement which will be referred to at the next meeting.

**Making Decisions.**

- Decisions should be made, where possible, by consensus
- Where this is not possible, by majority
- If the group cannot make a decision this will fall to the responsibility of the chair.

**Taking Action.**

- It is the responsibility of the representative of each agency to distribute information within their agency as necessary
- If an agency has agreed to accept a referral / undertake a piece of work, it is expected that they will do so
- If it is not possible to undertake this piece of work, this should be brought to the attention of the chair as soon as possible.

**Review / Self-evaluation.**

The Screening Group will be reviewed at least annually. This will include evaluation by looking at a sample of cases to identify whether there have been positive outcomes.

# Risk Indicator – Health and Care Services

Level of Risk:

**VERY HIGH RISK** – There is imminent risk of serious harm.

**HIGH RISK** – There are identifiable indicators of serious harm. The potential event could happen at any time and the impact would be serious.

**MEDIUM RISK** – There are identifiable indicators of risk of serious harm. There is potential to cause harm and this is unlikely to change unless there is a change in circumstances.

**LOW RISK** – Current evidence does not indicate likelihood of causing serious harm.

Separate consideration should also be given to the **Pattern – previous history, actions taken and compliance with statutory agencies and recommendations**. **Likelihood** of the risk re-occurring or are the sufficient protective factors to reduce the risk of harm or prevent it re-occurring. **Seriousness**; the degree of harm intended. **Imminence – are there any triggers warning signs that would indicate serious harm** – (refer to risk indicators). **Time-scales**; what time-scales apply to identify risk factors.

(Risk of Serious harm is defined as the likelihood of harmful behaviour of a violent or sexual nature, which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonable be expected to be difficult or impossible.)

**Imminent = Very High Risk**

- Immediate Physical/Sexual harm from another person (member of staff, resident, visitor etc)
- Misuse/errors with medication
- Withholding/obstructing medical treatment
- Limited knowledge and lack of understanding of symptoms that would indicate the need for medical attention.

**High Risk**

- High number of vacancies and use of agency staff
- Evidence of poor manual handling
- Evidence of poor infection control
- Evidence of poor nursing practice
- Systematic institutional harm
- Prolonged period between illness/injury and seeking medical attention

At this point consideration should be given to progressing to a Multi-Agency Strategy meeting within the Large Scale Protocol.

**Medium Risk**

- High staff sickness, use of agency staff
- Failure to meet and individuals care needs appropriately
- Hugh number of complaints
- Hugh number of adult protection referrals
- High number of falls
- Physical restraint
- Poor professional standards of practice and concerns re professional conduct
- Limited policies and procedures
- Poor implementation of organisational policies and procedures
- Unusual or suspicious injuries
- Unexplained or concerning behaviour of carers
- Hostile/rejecting behaviour by the carer

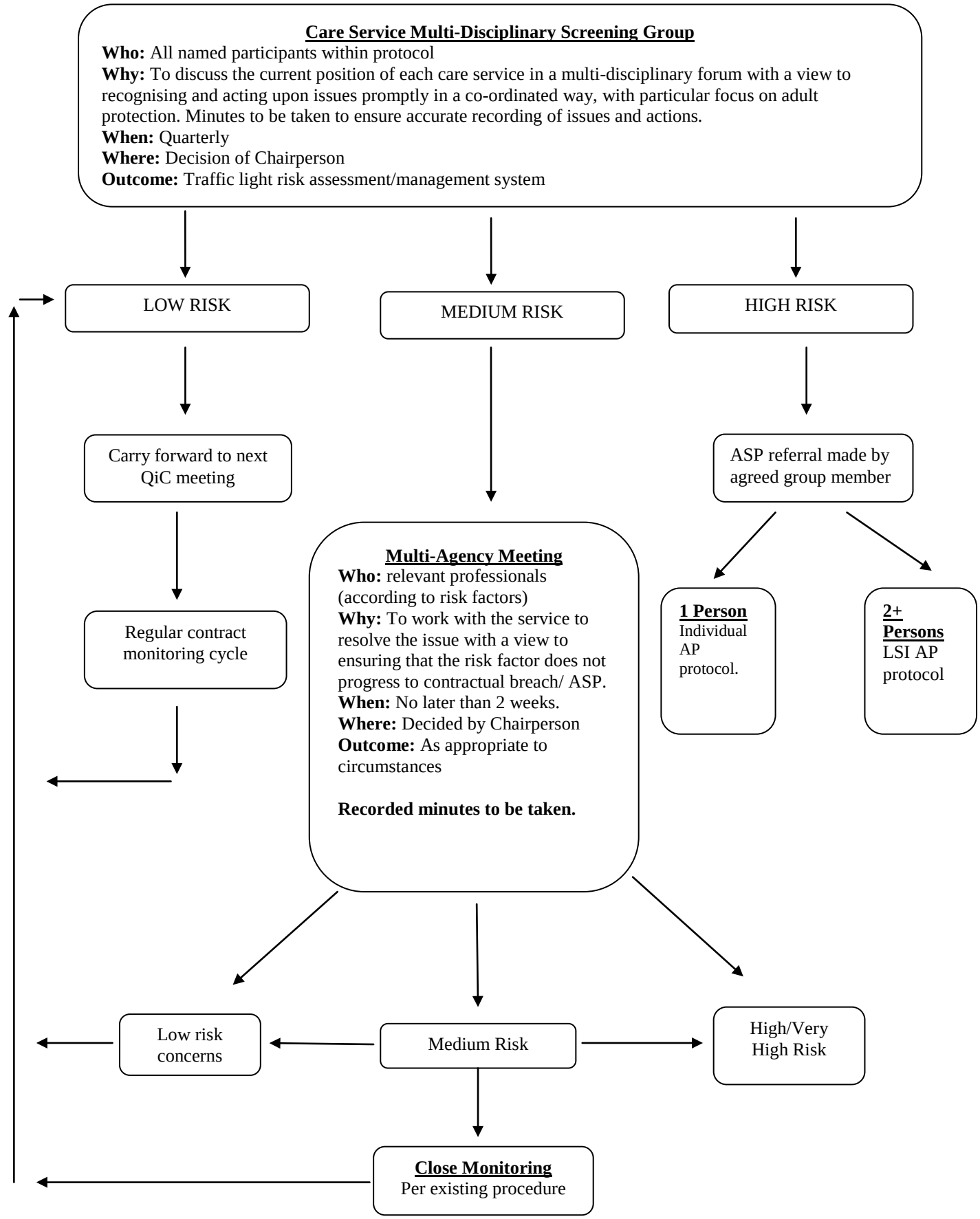
**Low Risk**

- All staff compliant
- Low sickness rate
- Consistency within staff team
- Strong leadership
- Clear documentation and recording of events
- Consistent reporting of incidents
- Minimal complaints
- Evidence of appropriate manual handling
- Evidence of professional practice and conduct
- Evidence of staff training in; Values, Dignity and Respect, Adult Protection, Manual handling and Infection Control.
- Appropriate referrals for medical treatment

Multi-Agency Screening Meeting Collated Feedback Form

| | |
|---|---|
| **Date of Meeting:** | |
| **Name of Care Service** | |
| **Current CI Grades** | |
| **Quality Assurance** | |
| **Operations** | |
| **NHS - Psychiatry** | |
| **NHS – Nursing/GP** | |
| **Care Inspectorate** | |
| **Police (If required)** | |
| **Other (please specify)** | |
| **Assessment/Decision** | |

## Screening Group Flowchart



**Appendix H**

# Early Indicators of Concern

# Good Practice Tools

# Early Indicators of Concern – Older People's Services

## Examples from the research

| | | |
|---|---|---|
| **1. Concerns about management and leadership**<br>• There is a lack of leadership by managers, for example managers do not make decisions or set priorities<br>• The service/home is not being managed in a planned way, but reacts to problems or crises<br>• Managers appear unaware of serious problems in the service<br>• The manager is new and doesn't appear to understand what the service us set up to do<br>• A responsible manager is not apparent or available within the service. | **2. Concerns about staff skills, knowledge and practice**<br>• Staff appear to lack the information, skills and knowledge to support older people/people with dementia<br>• Staff appear challenged by some residents behaviours and do not know how to support them effectively<br>• Members of staff are controlling of residents<br>• Members of staff use negative or judgemental language when talking about residents<br>• Record keeping by staff is poor | **3. Concerns about residents behaviours and wellbeing**<br><br>One or more of the residents:-<br>• Show signs of injury through lack of care or attention<br>• Appear frightened or show signs of fear<br>• Behaviours have changed<br>• Moods or psychological presentation have changed |
| **4. Concerns about the service resisting the involvement of external people and isolating individuals**<br>• Managers/staff do not respond to advice or guidance from practitioners and families who visit the service<br>• The service is not reporting concerns or serious incidents to families, external practitioners or agencies<br>• Staff or managers appear hostile when questions or problems are raised by external professionals or families | **5. Concerns about the way services are planned and delivered**<br>• There is a lack of clarity about the purpose and nature of the service<br>• The service is accepting residents whose needs they appear unable to meet<br>• Residents needs are identified in assessments, care plans or risk assessment are not being met<br>• The layout of the building does not easily allow residents to socialise and be with other people | **6. Concerns about the quality of basic care and the environment**<br>• The service us not providing a safe environment<br>• There are a lack of activities or social opportunities for residents<br>• Residents do not have as much money as would be expected<br>• Equipment is not being used of is not being used correctly<br>• The home is dirty and shows signs of poor hygiene |

Name of service: _____

| | | |
|---|---|---|
| **1. Concerns about management and leadership** | **2. Concerns about staff skills, knowledge and practice** | **3. Concerns about residents behaviours and wellbeing** |
| **4. Concerns about the service resisting the involvement of external people and isolating individuals** | **5. Concerns about the way services are planned and delivered** | **6. Concerns about the quality of basic care and the environment** |

# Early Indicators of Harm – Learning Disability Services

## Examples from the research

| | | |
|---|---|---|
| **1. Concerns about management and leadership**<br>• The manager cant or wont make decisions or take responsibility for the service<br>• The manager doesn't ensure that staff are doing their job properly<br>• The manager is often not available<br>• There is a high turnover of staff or staff shortage<br>• The manager does not inform Social Services that they are unable to meet the needs of specific service user | **2. Concerns about staff skills, knowledge and practice**<br>• Staff appear to lack knowledge of the needs of the people they are supporting e.g. behaviours<br>• Members of staff appear to lack skills in communicating with individuals and interpreting their interactions<br>• Members of staff use judgemental language about the people they support<br>• Members of staff are controlling and offer few choices<br>• Communication across the staff team is poor<br>• Abuse behaviours between residents are not acknowledged or addressed | **3. Concerns about residents wellbeing and behaviours**<br>• Residents behaviours change – perhaps putting themselves or others at risk<br>• Residents communications and interactions change – increasing or stopping for example<br>• Residents needs appear to change<br>• Residents skills change – self care or continence management for example<br>• Residents behave very differently with different staff or in different environments e.g. day centre |
| **4. Concerns about the service resisting the involvement of external people and isolating individuals**<br>• There is little input from outsiders/professionals<br>• Individuals have little contact with family or other people who are not staff<br>• Appointments are repeatedly cancelled<br>• Members od staff do not maintain links between individuals and people outside of the service e.g. family, friends<br>• Management and/or staff demonstrate hostile or negative attitudes to visitors, question and criticisms<br>• It is difficult to meet residents privately | **5. Concerns about the way the services are planned and delivered**<br>• Residents needs are not being met as agreed and identified in care plans<br>• Agreed staffing levels are not being provided<br>• Staff do not carry out actions recommended by external professionals<br>• The service us 'unsuitable' but no better option is available<br>• The residents group appears to ve incompatible<br>• The diversity of support needs of the group is very great | **6. Concerns about the quality of basic care and the environment**<br>• There is a lack of care of personal possessions<br>• Support for residents to maintain personal hygiene is poor<br>• Essential records are not kept effectively<br>• The environment is dirty/smelly<br>• There are few activities or things to do<br>• Residents dignity is not being promoted and suuported |

West Dunbartonshire Council

NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Name of Service: _____

| | | |
|---|---|---|
| **1. Concerns about management and leadership** | **2. Concerns about staff, knowledge and practice** | **3. Concerns about residents wellbeing and behaviours** |
| **4. Concerns about the service resisting the involvement of external people and isolating individuals** | **5. Concerns about the way services are planned and delivered** | **6. Concerns about the quality of basic care and the environment** |