NICE Social Care Guideline: Safeguarding adults in care homes

Stakeholder scoping workshop notes:

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SCOPE Overall impression

- **Does the scope make sense?**
- **Overall, do we have the right focus?**

Overall the scope makes sense but it would be good to also consider the following things:

- Framework needs to be more in line with Making Safeguarding Personal and the way we organise the guideline should be aligned in a way that it will fit in with policy around safeguarding.
- There is a big emphasis on prevention but there's nothing about learning, training and improving practice. Ensure that learning is embedded, not just for care homes but expanded for other staff/visitors who come to the care home (e.g. cleaners, cooks, hairdressers, etc).
- Institutional abuse.
- Clear definition of 'care home' is needed.

- Gap in Section 3 on commissioning, for example e.g. Section 42 of the Care Act places duty on Local Authorities to report safeguarding. We need to look at what happens after the referral such as the response and engagement of the organisation being referred. Some organisations refer themselves if they don't have their own procedures for investigation.
- The care home receives no support if they disagree with the outcome of a Section 42 investigation.
- Need to prevent baton passing, it will be important for the Guideline Committee to have a sound understanding of the legal framework.
- Good communication between all services and staff involved.
- Best practice guidance is available but there is a lack of awareness of it by a range of managers – another guideline won't necessarily deal with it. There is clear guidance on what constitutes good and outstanding – the group wanted to know how this guideline will add to that? NICE guidance – to deal with variation in practice and develop quality standards which feed into Care Quality Commission (CQC).
- Consider adding NICE Quality Standard 24 to the list of related guidance.

Section 3.1 Who is the focus? The population

- ***We are including residents and people who may use care homes for day care or respite care within that definition. Are you happy with that definition?***
- ***Are there any groups that we should exclude from our definition?***

- Include people who are about to arrive at care homes.
- Ensure we don't explicitly exclude any groups.
- Respite care – good to go beyond people living in care homes.
- Intermediate care (care delivered by a workforce which has more expertise in different care for different settings) e.g. arrangements with NHS staff and carers and staff in the care homes.
- Explicitly state self-funders.
- Registered care homes.
- Note to NICE – there is a need for future guideline on safeguarding young adults in the community.
- Local Authorities have safeguarding responsibilities for all people present in their area. There are issues associated with out-of-area placements, as once people are placed out of area commissioners are very hands off. When the enquiring authority is the same as the commissioning authority they have a lot of clout over the provider.
- Supported living vs care homes – very blurred boundaries as lines are not clear so guideline might need to mention that this can be relevant in some settings.
- Representation of police to feed in within the guideline as some parts of the guideline might be relevant to them.

Groups that could be excluded:

- Recognise that there is a distinct population of younger adults which have different needs. The guideline will need to define this group. Question is whether we exclude this group?
- Specialist units (e.g. dementia).
- Exclusion of prison misses some incredibly vulnerable adults that need care so this needs careful consideration.
- Group housing.
- Supported living but recognise that some non-care home settings are delivering similar care to that of a care home. Also there are care homes within supported living arrangements – not technically care home but relevant delivery of care. Some supported living is under CQC if they are delivering person-centred care. Perhaps the scope would be clearer to say "registered under CQC" (i.e. registration to delivering residential nursing care). This would bring in supported living (if registered).
- Relatives of a resident e.g. staying overnight.
- Staff? Will they be excluded as well because they also can be vulnerable – is there a way we could acknowledge them in the scope although they aren't the main population the scope is aimed at. – POSSIBLY IN THE TRAINING AND SKILLS SECTION.

Section 3.3 Activities, services or aspects of care

- ***Are these the most important areas for the guideline to tackle?***
- ***Are we right to focus particularly on prevention, identification and early management of safeguarding concerns?***
- ***What particular aspects of partnership working are most important for us to cover?***

Are these the most important areas for the guideline to tackle?

- Ensuring that other people who go into the care homes e.g. hairdressers and family also need training and to have an understanding about safeguarding issues (learning from practice).
- How can care homes learn from experiences they have had and how can they communicate this to all staff working there.
- Getting staff to understand what abuse actually is and when and how it can happen.
- People's attitudes and understanding of what abuse is needs to be addressed
- Risk assessment – fewer older people are subjected to a risk assessment and this is an opportunity that can be used to protect the individual.
- Early warning signs and focussing on quality and any complaints. Change in leader or manager in a care home can really affect the quality of care in the care home. The role of leadership can be really significant within care home settings, managers and leaders should have appropriate training.

- Link between provider and safeguarding board, housing association/board, community nursing, information sharing, Care Quality Commission (CQC). More streamlined communication between NICE and CQC.
- Child abuse and neglect and Transitions between hospital and home guidelines – may need to link to these
- Guidance should remind managers that they can be prosecuted too, not just care staff e.g. the Veilstone care home case.
- Include commissioners in some of the recommendations – note that the commissioning milestones are changing.
- Unsure where undertaking investigations would fit in. Staff are often not equipped to undertake investigations. So with the Care Act there are 3 pathways:
    1. Issue not considered safeguarding, the care provider can undertake an investigation.
    2. Issue considered safeguarding – the care provider to undertake an investigation (on behalf of the Local Authority).
    3. Issue considered safeguarding – the Local Authority undertakes the investigation. It is important that the care provider is able to undertake these investigations – identify learning and embed the learning.

- Process of regulation of the registration of the providers is failing. Individuals are struck off for poor practice but then move to different care homes and continue safeguarding issues. Consider due-process in recruitment – can't get a reference (the previous care home just want rid of that individual). How to exclude shocking practice – not the individual care home but the wider sector.
- How do we get the resident's voice into this? These people are usually disempowered. It would be good to use this opportunity to empower people and give them the autonomy.
- Nutrition, hydration, tissue viability are all part of neglect.
- Management contaminating the evidence.

Are we right to focus particularly on prevention, identification and early management of safeguarding concerns?

- Concerns about "prevention" – acknowledged it was really important to find ways to prevent safeguarding but there is a risk that the guideline becomes too broad. Need to be clear about what the guideline will cover – the group felt it should not cover the broader concept of quality but just specifically safeguarding and that it should be made clear here. The scope is perhaps not quite clear on the distinction at the moment. CQC reference might be misleading.
- Should the scope start with identification, and that prevention might come through from identification and the other sections rather than include as a broad topic in its own right.
- Abuse might be easier to identify whereas neglect is a grey area. The Care Act took away the concept of 'significant harm' which leads to big discussions about whether an issue is safeguarding or not. Where does it stop and start?

Deliberate acts or wilful acts or disregard? Everything seems to come under abuse. What about a busy practitioner who makes a mistake? If it needs a protection plan then you can consider it safeguarding. Guidelines need to thrash this issue out and identify responsibilities of the provider. What are the key indicators? Proportionality is such a key part of the Care Act. Different approaches to different situations. Criminal neglect? Serious incident policies – care homes don't necessarily have that governance. Safeguarding is widespread, multifactorial (not necessarily happen to one resident but has potential to affect other residents). If it's very serious this would mean institutional safeguarding. There is definitely a lack of clarity around identification (i.e. what is a safeguarding concern).

- Mental Capacity Act and how this guideline will inter-relate with that – our guideline can refer to the new NICE mental capacity guideline when it is completed. The group felt the guideline would need to take into account new things coming in around mental capacity.
- Educating people – what is abuse, what sort of care do they need, recognising it is just not about abuse happening in the care home? People may have also experienced abuse in the family, partners etc.
- Training for staff is definitely key – (e.g. Adult safeguarding doc which covers roles and training for health care staff).
- Flesh out partnership working for referrals (appropriate and inappropriate referrals e.g. Nursing and Midwifery Council) and responsibilities.
- Organisational risk to the care home, medication etc. But things that do not get raised are issues like discrimination towards the individual, personalised preferences.
- Commercial fear (e.g. fear of CQC inspections). Care home staff feel under-valued. Emphasis on the care home staff themselves e.g. there needs to be a bit of room for human error where staff are not penalised or made to feel bad. Learning from mistakes and reflecting on the things that have not gone right and how they can be improved.
- NICE recommendations = use of wording 'consider' and 'suspect' – relevant for No. 2 and 3.
- Failure to escalate – see the 'Decision aid for making adult safeguarding referrals' by Royal College of General Practitioners (RCGP).
- Enabling staff to undertake certain tasks including training (handovers, staff supervision). To go beyond permanent staff – also relevant to visitors who are still staff (e.g. cleaners, hairdressers, health visitors, podiatrists etc).
- When we think about training we need to also think about the specific audience as the range of care home staff is so wide and different people will have specific training needs.
- RCGP training videos.
- There are some gaps:
    - What happens after the referral? Such as:
    - Referral
    - Responding to referral

    - Reporting
    - Enquiry
- There is currently no process for referrals for physical (bruises) and sexual abuse e.g. relationship with the Police and GPs does not have the forensic expertise to deal with these queries.
- Family and peer support for individuals – there is a vulnerability here. It is about increasing value of need.
- Abuse of people's human rights – people not having control of their own choices or making choices.

What particular aspects of partnership working are most important for us to cover?

- Consider adding the following: Police/housing, CQC local health providers, local communities and expert individuals (e.g. dietician).
- Working together to undertake an investigation but also how the care home provider is represented on the safeguarding board or how they engage with the board and best practice around this. Those that don't engage become isolated from the process. But there is a complex landscape – care home providers might want to engage but are confused with where to go.
- Good signposting would be helpful. Understanding where to get information (for the investigators) e.g. nutritional issue they may not have that knowledge, ensure they bring in an expert. Problems can be exacerbated if an investigator presumes they know enough about the issue. Important to know your local experts in your area and ensure you tap into that resource. Seems like an issue to explore in some way (even if some of it falls from other topics).
- Care homes are often not linked in with these partnerships or also perhaps they aren't linked into some of the big related organisations. The group were concerned about representation for the care homes basically and ensuring they are linked into networks/processes.
- In terms of training, it would be important to make it clear what was going to be covered here e.g. not a competency framework (which are already available from other organisations). Perhaps the guideline would only minimally cover this in terms of signposting to other guidance in this area. The guideline may concentrate on specific training programmes/packages as interventions. Training is important in terms of prevention.
- Information sharing e.g. RCGP info sharing guidance for children was recently published – would be good to recommend developing something similar
- Lack of accountability and funding
- Alerts for various things would be useful
- Difference in the commercial ethos – sharing good practice. A lot of care homes cannot share good and bad practice with one another honestly
- Culture that links to prevention. Safeguarding is not separate entity is it part of the holistic approach.

- **Categories of abuse**

  - ***Are there any categories of abuse and neglect which need more focus than others within the guideline?***
  - ***Are there any categories of abuse and neglect which we should not cover or should deprioritise in our work on the guideline?***

- Encourage staff to conceptualise abuse as opposed to categorise the types of abuse: institutional or individual abuse and in either case there can be omission.
- Mechanical constraints – anything which restricts movement.
- Physical intervention being wrongly or overly used.
- Medicines management e.g. mistakes or overuse of sedation.
- Least restrictive options.
- Self-neglecting within care homes needs to be talked about – in addition to the 4 categories. This would be the individual aspect of omission.
- Pick out characteristics of abuse and neglect as well as categories e.g. individual vs. institutional abuse, as well as the dynamics of abuse too.
- Time element of abuse. A single act can be just as damaging as several acts. It is important to consider the different timeframes.
- Need to mention historical abuse as carers may not initially notice signs of neglect.
- Categories of abuse has already been done and does not necessarily need to be in this guideline.
- Other types of abuse might be relevant: CCTV, internet etc - impacts on human rights and abuse of your autonomy. We need to focus more on this.
- Deprivation of Liberty Safeguards (DOLS).
- We should not be excluding any forms of abuse (e.g. what other forms of exploitation should we be thinking about?).
- Resident to resident abuse (sexual exploitation).
- Staff who lie to residents (changing the culture in the care home).
- The group overall felt this was a useful list of categories of abuse. The fact that it is consistent with the Care Act seemed logical to them and that deviating from that might create confusion. They were keen to ensure that it wasn't being seen as an exhaustive/finite list though, and that there were finer details (e.g. different age groups factor into different ones) and that "neglect' was not so clear to define.
- Not all of the categories are as prevalent in this setting e.g. domestic violence. Modern day slavery in care homes – perhaps more about potential exploitation of the care home workers, again perhaps limited or less prevalent.
- Discriminatory abuse – this area is not well understood in how it manifests. Staff discrimination (maybe institutionally) of residents on the basis of age etc. This might come out as a reason behind other abuse.

- Consider adding the Prevent Agenda (counter terrorism/radicalisation – government agenda). These individuals often have care needs. Perhaps low risk in care homes but consideration might be needed.
- Psychological effects.
- Neglect and acts of omission.

Unmentioned Categories:

- Coercive control might come under psychological
- Emotional neglect
- Social media related abuse i.e. grooming , radicalisation, FGM
- Financial abuse also known as 'Cuckooing' (for example, by befriending a person who may lack capacity, moving into their home with them and taking over their assets)
- Organisational abuse

- What counts as neglect or abuse as they cover a few other domains?
- Take into account people's immediate prior experience when adults are going into the care homes.

Areas that will not be covered

Are there any other areas we should clarify we are not covering?

- Different local authorities have different ways of implementing and reporting the same guidance e.g. is a medication error a practice standard or a safeguarding error?
- Local authorities need to be more consistent
- Information flow and the practice in terms of how they manage cases and the time limits of the cases
- Once you've raised a concern, there needs to be communication coming back from local authorities
- Delays in reporting can often be linked to the police
- There should be something about what things the organisations themselves should take responsibility for responding to as opposed to the local authority
- Clear guidance about what you could and shouldn't be doing without the local authority telling them what to do
- Advocacy organisations are shrinking in numbers
- Cost implications for support and types of therapies too
- Capacity issues about care homes are able to increase safeguarding
- Clarity around the law of capacity issues and assessments
- Care homes that provide outreach services (e.g. locality).
- Consider clarifying that the guideline won't be covering competency frameworks.
- Criminal proceedings – generally happy that this was being excluded, but there might be a difficulty in the boundary of this, for instance, certain behaviours would jeopardize proceedings e.g. police seize records and care homes should

still be left with their own copies so that they can address the issue. Some process areas could be covered in this guideline whilst not covering the criminal aspect itself. Often safeguarding involves a criminal investigation – the guideline can reflect on the care home process/activities but not the criminal aspect so maybe need to make this exclusion clearer.

- Also add quality improvement or broader quality of care (not considering the broader agenda basically).
- Safeguarding board - needs to be a bit clearer about the interface (i.e. not covering the safeguarding board work itself but the partnership working with the care home is important). It was felt that the guideline would likely be referring to the board but not making recommendations on how they work/operate.
- Courts.
- Investigative work of CCG/commission organisation and local authorities.

Section 3.5 Key issues and questions.

- ***Are we asking the right questions?***
- ***Is there anything we are missing?***

- It would be good to see some human rights terminology included
- Include what care homes should be doing to keep self-funders in the loop about safeguarding policies
- Ensure the guidance gives self-funders a voice
- What constitutes financial abuse –need to be wary about how we present things like this as it is highly sensitive and political
- Questions are quite broad.
- Prevention: This is broader than the scope of the guideline
- Identification: Useful to separate neglect from abuse as there are different issues (signs/symptoms and different ways to distinguish between them). Neglect is not commonly understood so it would be useful to separate from abuse. Safeguarding concerns are most often concerning abuse, probably because neglect is not so easy to understand – and perhaps picked up externally (hospital visit or self-reports). There is disparate experience by care home providers which then leads to variation. The leader of the care home service is key. There is confusion as to what to report and when – do we report every time? What is significant harm? Our expectations of what is ok – what tolerance do we have on these things? Generally speaking, there is over-reporting of incidents of safeguarding and this is breaking the system. CQC are currently reviewing the notification guidelines but it is not available yet - interlinking with that work and simple guidance around this area is needed.
- Managing concerns: Learning would come out of this section but that there was a lot to cover in that first question. Ensure the guideline covers reporting too here. Investigation, learning from it then embedding that learning and changing practice. The outcomes of investigations can be distressing and not necessarily

in the best interests of the adult – so there can be unforeseen results. Effectiveness of making it personal is critical. Thresholds can be person-centred. But also acknowledged the bigger potential of the issue (e.g. if an individual is not bothered about the concern but it would affect others if it continued) so person centred but also consider the wider care home. Personal to every individual not just the one person.

- How effective training can be in preventing future instances. The guideline should cover learning from safeguarding/reviews (not just from training).
- Q1.1 – Include risk assessment in search.
- Q1.2 – Look at open/closed culture of care homes- communication from care home, culture and complacency, behaviours, partnership working.
- Q2.1 - Change signs and symptoms to indicators.
- Q2.2 – Might link in with training and skills (e.g. whistle-blowing). Families might be a hindrance e.g. people often have low expectations and guilt from family that they've left vulnerable adult in a dire state at the care home. Also care homes might be fearful over consequences for raising issues, hence not reporting.
- Q3.1 - Implies two separate questions - NEEDS TO BE SPLIT INTO TWO QUESTIONS:
    - Reporting – procedural bit
    - Response- speed of referral
    - Preparation for a referral – how to gather the information, contamination of evidence , different procedures from diff authorities makes it confusing for staff- e.g. what's an incident? What's safeguarding? – this leads to people not reporting
    - Lower level staff adds to prevention – subjective interpretation of what's a safeguarding issue.
    - Being responsive/non-responsive to local authorities
- Q3.2 - Self-funding resident – issues around this, access to advocacy, asking people within care homes – asking residents what they would like once the technical/procedural process i.e. risk assessment has been undertaken.
- Q4.1- Religious groups, advocates, fire services (environment, fire safety),
- Transparency and accountability needs to be mentioned in the question.
- Q5.2 – To also consider the following things:
    - Training given from diff providers- from online to practical classes:
    - Training effectiveness is Subjective – is it relevant to person's role?
    - Local data can be used to demonstrate effectiveness
    - Looking at performance appraisals a time period after training
    - Qualifications at point of entry – e.g. English, literacy, diff cultural background
    - Skills should include literacy and numeracy sufficient enough for them to do their jobs.
    - Safeguarding supervision (diff to clinical supervision) – a good measure of effectiveness of training. There is some guidance on how this should be delivered.

- Support – what support do workers in care homes need which will help with their responsiveness to care home
- Over usage of agencies = barrier
- Continuity of staffing = barrier
- Number of referrals = proxy to training?
- How do homes know that staff from agencies have the right training?
- Learning from previous inquiries/enquiry e.g. facilitator
- Staff turnover - barrier
- Resources - barrier

Section 3.2 Setting
Have we included and excluded the right settings here?

- Use same terminology throughout
- Need to think about whether prisons should or shouldn't be included - prisons and wheelchair issues - prisons and safeguarding is a growing issue. Sometimes wheelchairs are not allowed in prisons because they can be used as weapons
- Not helpful to exclude supported living and don't need to necessarily include
- Think about further education – college and care homes
- Ward environments which are not dedicated to care home facilities
- We shouldn't exclude hospitals
- Generally happy not to include supportive living but some of these non-care home settings are delivering similar care to that of a care home. Also there are care homes within supported living arrangements – not technically care home but relevant delivery of care. Some supported living is under CQC if they are delivering person-centred care. Perhaps the scope would be clearer to say "registered under CQC" (i.e. registration to delivering residential nursing care). This would bring in supported living (if registered).
- Could also add "Specialist units (e.g. dementia)" to the excluded list.
- Whilst acknowledging that prisons sometimes offer similar care facilities they were happy not to include them as a group – different processes etc.

Section 3.6 Main outcomes

Which are the most important outcomes?

- Context – mortality and morbidity – look at the average age of people living.
- Things that are not included: Autonomy and self-determination.
- Satisfaction levels – this may not always be accurate or reliable
- Access to services would be more beneficial (e.g. dentist)
- Safeguarding needs to be measured on other things
- Mortality in people with learning disabilities, autism etc
- Explain what these outcomes are - they are not the outcomes of the work of the guideline itself, which people may read this as.

- Skills for Care – outstanding services (collation of pointers). Intervention tool rather than an outcome.
- Adult Social Care Outcomes Framework (ASCOF) data set – in particular Safeguarding Adults Collection (SAC) statutory return. Also ASCOF outcome measures.
- **Satisfaction levels and personal outcomes are most important.**
- Individual outcomes after a safeguarding issue
- CQC outcome - safety and caring domain

Equalities

Are these the right equality issues?
Please raise any issues that you identify as being relevant to the equalities theme.

- Discrimination in relation to the family carers
- Ethnicity
- Placing restrictions on families
- People are increasingly bringing in their own technologies into care homes
- Tracking devices – whether or not these are appropriate to use
- Particularly emphasis on people with no family, friends, advocates
- Self-funders
- People who have difficulty in communication (e.g. people with learning disabilities)
- People lacking capacity

Who the guideline is for
Are these the right audiences for the guideline?

- Self-funders
- Initially discussed about the general public – an understanding that the guideline will be for managers and professionals delivering care but the group were unsure what the public will get from this guideline. Also think about producing a Quick Guide.
- Consider adding “advocates” to the “Adults living in care homes, their families and carers” bullet point i.e. acknowledging them as a member of the support network around the person.
- Consider adding Quality Surveillance Group (linked to NHS England) – relevant statutory organisation/group. This group might be included in “Health and social care commissioners of residential care for adults.” Could be placed under “may be relevant” as the groups remit might be too broad - more on quality than safeguarding specifically.

GC COMPOSITION
Prioritising members. Which are the most important roles for core committee membership
• The list was a very good starting point • Advocacy services • Be cautious in taking service users perspective • Manager who has worked in several different types of services • Local Healthwatch • Families and friends as they will have a non-institutional version of what happens • CQC regulator – this was mentioned but unlikely to have on the committee • CCG designated professional (nursing and medical background) • Geriatrician – variable input into the boards but in some areas they have them involved • Clinical Commissioning group (CCG) pharmacist • Local Authority Care Quality Improvement Team (sometimes called Care home Support Team) • Safeguarding board member – be more specific e.g. chair or designated professional • Integrated nursing team member • Quality and safeguarding networks • Best interest assessors • Mental health assessors/psychiatrists • Voluntary and independent sector • Healthwatch – might be same as activities co-ordinator/holiday/respite worker
Members that could be included as co-opted members or expert witnesses
None