SOMERSET SAFEGUARDING ADULTS BOARD

ORGANISATIONAL ABUSE GUIDANCE

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ORGANISATIONAL ABUSE GUIDANCE

1 INTRODUCTION

1.1 This document provides guidance for a multi-agency approach to responding to concerns in relation to the Organisational Abuse of adults with care and support needs.

1.2 Its purpose is to help staff give better informed and more effective support to people who need an adult safeguarding service because of Organisational Abuse.

1.3 It applies to all services that work with adults with care and support needs, regardless of who is funding their support or whether they are regulated by the Care Quality Commission (CQC) or not.

1.4 Appendix 1 must be referred to by any professional who is unsure about the scenario they have encountered or who is unfamiliar with this type of abuse and neglect:

2 DEFINITIONS

2.1 Definitions as prescribed in related Care and Support statutory guidance.

2.2 Organisational abuse: 'Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.'

2.3 Neglect and/or acts of omission:

- ignoring medical needs/treatment

- emotional or physical care needs
- failure to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and heating

3 EARLY INDICATORS OF ORGANISATIONAL ABUSE

3.1 A combination of research and safeguarding practitioner experience has identified a number of factors that could be early warning signs of organisational abuse. Information and awareness about these early indicators can support practitioners to identify concerns and feel confident that what they have observed is valid, enabling them to act to protect people from abuse. These indicators are listed in Appendix 1. However, this is not a definitive list, and practitioners may identify other indicators not included in the appendix.

3.2 The indicators can be grouped into six key themes. These themes provide important information about key aspects of service design and delivery which increase the risks of abuse and harm for people.

3.3 The six main areas to think about are:

1. **Concerns about management and leadership**
   The people who manage the service and other managers in the organisation. What are they doing, or not doing that might put people at risk of abuse?

2. **Concerns about staff skills, knowledge and practice**
   The people who work in the service. What are their skills and practice like? What are they doing or not doing that might put people at the risk of abuse? This is not just people who work as care workers or nursing staff. It could also include managers and other non-care staff who work in the service.

3. **Concerns about peoples' behaviours and wellbeing**

The people who live in, or use, the service. How are they? Are they behaving in ways which suggest they may be experiencing or at risk of abuse? What are they or their friends/relatives saying about their care?

4. **Concerns about the service resisting the involvement of external people and isolating individuals**

Are the people receiving support cut off from other people? Is it a "closed" or an "open" service? Does the service resist support from external agencies or professionals?

5. **Concerns about the way services are planned and delivered**

The way in which the service is planned and whether what is actually delivered reflects these plans. Are people receiving the levels of care which have been agreed? Are the people who use the service a compatible group? Is the service clear about the kind of support it is able to deliver?

6. **Concerns about the quality of basic care and the environment**

Are basic needs being met? What is the quality of the environment like?

3.4 It is important to note:

1. This guide will help practitioners to record, reflect, talk to someone and ACT.
2. It is not necessary for there to be concerns in each of the six key themes, for there to be a concern about a whole service.
3. A pattern of concerns is *not proof* of abuse and abuse can happen when indicators of concerns are not apparent.
4. The use of this guide does not replace listening directly to people using services. On the contrary, it gives an important reason to listen more closely before and after concerns are raised.

3.5 The SSAB Service Monitoring Checklist can be used to record concerns and shared alongside a safeguarding alert (referral) Safeguarding alert form - Somerset Council

4 WHISTLEBLOWING

4.1 A whistleblowing referral may be the catalyst for identifying wider concerns about a service. Whistleblowing is different to a complaint in that it will be made typically by an employee or an ex-employee of the organisation. The person may or may not have tried to raise the issue with their management. Ideally, they should have done so, but clearly there are times when an employee will feel too intimidated to do so. Where a whistleblowing is actually a safeguarding concern about an individual, this should be dealt with initially through the individual safeguarding processes to ensure that the person is safe. Where there are wider implications about the service, these may need to be followed up through organisational safeguarding processes.

4.2 It is essential that information is taken carefully from whistleblowers whatever their motives appear to be. Just because someone has fallen out with an employer does not necessarily mean that the information they are passing on is not valid. As with any other enquiry this will need to be balanced with other information.

4.3 Each organisation should have its own Whistleblowing Policy to follow.

4.4 The Care Quality Commission National Customer Service Centre can also be contacted on: 03000 616161

5 DECIDING IF THE CRITERIA ARE MET FOR AN ORGANISATIONAL ABUSE ENQUIRY

5.1 In addition to the local authority carrying out safeguarding enquiries for individuals living in Somerset, all safeguarding concerns that are raised about a service provider are logged by the local authority Quality Assurance Team on a separate provider record. These logs are reviewed every three months, or sooner if significant concerns are raised, in order to determine if the decision-making process for determining whether an Organisational Safeguarding Enquiry is required should be initiated.

5.2 The Quality Assurance Team works proactively with care providers – often visiting before there are significant concerns and providing advice and signposting, to try and avoid the need for a formal enquiry.

5.3 There is a need for professional assessment and judgement in determining when poor practice becomes Organisational Abuse. Addressing the following four key questions will support the decision to initiate an Organisational Abuse enquiry:

i. Are the concerns of a type to indicate Organisational Abuse? Do they feature on the Early Indicators of Concern Full Checklist in Appendix 1?

ii. Are the concerns of a nature to indicate Organisational Abuse? Is the behaviour widespread or generally accepted within the setting? Is it sanctioned, accepted, or ignored by management and/or supervisory staff? Does it occur against the wishes of an ineffectual management group?

iii. Are the concerns of a degree to indicate Organisational Abuse? How long has it been occurring and what is the impact on the adults using the service? Is there a risk of repeated or escalating incidents?

iv. Is there a pattern and prevalence of concerns about the organisation? Are the same incidents reported over time or by a number of different agencies?

5.4 It is not necessary for all four questions to be answered positively. A one-off serious incident may be enough to trigger consideration regarding whether Organisational Abuse has/is taking place.

5.5 This will include a review of all the concerns and an evaluation of all current sources of evidence, including making enquiries of an appropriate range of people and services including:

- Concerns raised by adult(s) involved or their family or friends
- the previous safeguarding history of the provider (including other services operated by the provider)
- reports by CQC if within the last year – the previous and current status of the Service / organisation
- Local Authority and relevant Integrated Care Board (ICB) Contracts / Quality Assurance Teams – previous or current evidence of non-compliance
- Local Authority feedback/complaints function – history of concerns / complaints (and positive feedback)
- Police – past or current concerns
- Health professionals who may visit e.g. GPs, district nursing, ambulance service, Care Home Support / Liaison etc. Also, if relevant, the history and pattern of referrals to secondary care or emergency department attendances
- practitioner views – any feedback arising from reviews or individual safeguarding enquiries
- Feedback from commissioners – any feedback arising from commissioning and contract management processes

- Contact from whistle-blowers and or family members that allege organisational abuse
- Where the service is a provider of NHS funded care the involvement of the commissioner should be considered

5.6 The decision making will evaluate the issues that are identified under the headings of the six key themes, and will include a recommendation about next steps. This recommendation will be reviewed by the Safeguarding Adults Manager who will decide whether or not to begin an Organisational Safeguarding Enquiry under Section 42 of the Care Act (2014)

5.7 If the decision is made not to proceed with an organisational safeguarding enquiry then the Safeguarding Adults Manager should record how the issues arising are to be followed up e.g. by a safeguarding or quality assurance visit to the provider, through individual enquiries, by a visit from another service such as the Care Quality Commission, or by Adult Social Care Services.

5.8 The decision-making process and rationale for actions will be shared with the management of the service under consideration.

6 ORGANISATIONAL SAFEGUARDING ENQUIRIES

Partnership Working: Key Points

6.1 Responding to organisational abuse is likely to require complex coordination of different organisations both for information and for direct involvement in the enquiry. Drawing upon the knowledge and expertise of the Somerset Councils Quality Assurance Team, the Integrated Care Board, the Care Quality Commission and other partners will be an important early step in formulating an effective approach. It is important that everyone involved is aware of their respective roles and responsibilities and their duty to cooperate in the enquiry.

6.2 Under the statutory guidance of the are Act 2014 Somerset Council will lead and co-ordinate organisational safeguarding enquiries incorporating multi-agency knowledge, skills and information sharing which are essential for best practice, sound decision making and securing positive outcomes for the people using the service.

Who Leads Safeguarding Enquiries

6.3 The Safeguarding Adults Service Manager will normally coordinate all organisational safeguarding enquiries including the chairing of meetings. Exceptionally if this is not possible or the concerns are of a very high risk, the Principal Social Worker/Strategic Manager Safeguarding and DoLS or Service Director Operations Adult Social Care should be consulted and agreement reached about an appropriate chair and co-ordinator. Each participating organisation will nominate a lead to support the enquiry. In situations where the service also supports children under the age of 18, the enquiry will be managed by Childrens Strategic Safeguarding Manager.

6.4 The relationship between social care and any police/criminal investigation will need to be confirmed for each individual enquiry. The balance is between preserving evidence and enabling the police to pursue their investigation and ensuring that all adults are safe within the setting.

6.5 Partnership working is key; each principal safeguarding organisation in particular, the Council, Police, Integrated Care Board and Care Quality Commission has a specific role and functions that combine to create an effective safeguarding process. Operationally, this requires careful coordination and avoidance of deference to, or dominance of, any single organisational perspective or function.

6.6 Active and co-operative behaviour by the service provider is expected and essential. Depending on the type of concerns and the seniority of staff involved it may or may not be appropriate for the provider to actively make enquiries.

This will need to be decided in each situation by the local authority as the body with overall responsibility for the safeguarding enquiry. It will be important to understand the service providers own processes (for example disciplinary procedures), and how any intention to use these relates to the safeguarding concern. It is key that the service provider takes responsibility for the abuse and the impact of it. Where their internal procedures appear to have allowed a culture where abuse can take place it is essential that this becomes part of the enquiry.

6.7 It is essential that, where providers are undertaking enquiries, there is clarity about what these should cover, the timescales involved, and how the outcomes will be fed back. Where these conditions are not adhered to, consideration must be given to how to escalate the concerns to ensure they are managed.

6.8 When an enquiry involves a number of people who have experienced abuse, or are at risk of abuse, the issues are often complex, involving standards of service as well as a series of individual enquiries. An organisational safeguarding enquiry may involve a number of individual safeguarding adult enquiries to address allegations of abuse specific to each individual. Under The Care Act 2014, the Local Authority has lead responsibility for adult safeguarding concerns. The local authority can delegate responsibility for enquiries to appropriate agencies but it will retain the reasonability for quality assurance of these enquires. In carrying out this responsibility the Chair will co-ordinate the overall enquiry and ensure that all relevant agencies are involved.

7 ORGANISATIONAL SAFEGUARDING MEETINGS

7.1 When it becomes evident that the degree and severity of safeguarding concerns indicate that an organisational safeguarding enquiry is needed, the

local authority will arrange a “Raising Concerns” multi-agency meeting. Agencies that will be invited to attend will vary according to the specific circumstances of the enquiry but could include the following key partners:

Police – individual safeguarding concerns that require the involvement of the police should be secure emailed to the Lighthouse Safeguarding Unit. The chair of the individual safeguarding enquiry will then liaise with the police as appropriate.

Care Quality Commission – must be informed of any concerns relating to a regulated service.

Local Authority Commissioning and Contracts – must be informed of safeguarding concerns relating to any provider operating in Somerset irrespective of whether services are commissioned.

Health – where services are commissioned by the Integrated Care Board (ICB), NHS England or public health e.g. via Continuing Health Care (CHC), Funded nursing care (FNCC) or as part of a joint package, the ICB must be informed.

Other Local Authorities – where placements are commissioned by another commissioning body for example, another local authority, they should be notified of the referral and involved throughout. While the council retains the lead safeguarding role for all safeguarding concerns, placing commissioning bodies retain a duty of care towards the adult and should be expected to fulfil this role in co-operation with the safeguarding enquiry. See ADASS-Out-of-area-Safeguarding-Adults-Arrangements-Protocol for further details.

7.2 Where safeguarding concerns relate to a council provided service (provision or assessment etc) care must be taken to ensure that there is a

clear separation of interests i.e. all staff involved in the safeguarding enquiry should have no direct relationship to the matters under enquiry.

7.3 For the most serious situations where serious harm has taken place or is suspected:

- the Service Director, Adult Social Care at Somerset Council must be informed. A decision will then be made about information being passed to senior managers to ensure appropriate involvement and support from services
- where criminal offences may have been committed it is crucial that the first enquiries are done by or with the police
- identify the initial internal resources to co-ordinate and undertake the enquiry, including legal advice
- organise a multi-agency meeting to agree an 'Enquiry/Assessment Plan' covering both individual allegations and the organisational setting
- identify and implement a clear communication strategy
- ensure that the potential need for advocacy is considered

7.4 An initial raising concerns meeting should be called as soon as possible. Depending on the level of risk and the complexity of the concerns a balance may be needed between ensuring the maximum number of partners round the table and ensuring people's immediate safety. Where the situation is extremely serious an immediate meeting/discussion may be required to start the enquiry process. This should be a rare occurrence, but it is expected that all partners will respond when this is required.

7.5 The initial raising concerns meeting will need to undertake a preliminary risk assessment based upon existing knowledge and agree an interim safeguarding plan covering both individual concerns and the care setting. This must include a plan to keep existing adults safe. The interim risk assessment should also include the option of suspending further placements.

7.6 Follow up meetings will be needed to ensure that actions are completed and plans revised as required, including:

- implementation of the enquiry
- considerations of report(s) completed by partners
- evaluation of the enquiry and evidence obtained
- determine if abuse/neglect has taken place in either/or individual concerns and the care setting (organisational abuse)
- consider the circumstances and potential needs of perpetrator(s)
- agree an ongoing safeguarding plan which is likely to have both short and medium term actions
- agree time scales for review of safeguarding plan
- agree circumstances where re-evaluation of the situation will be required
- agree an action plan for the service provider
- monitoring and review of the action plan for the service provider
- debrief and consider learning points and wider implications
- receive feedback of follow up by provider e.g. disciplinary processes, referral to Disclosure and Barring Service (DBS) and/or appropriate professional bodies such as Nursing and Midwifery Council (NMC), or the Health and Care Professions Council (HCPC)
- consider a referral to the Safeguarding Adults Board, SAR or other actions across the safeguarding partnership
- case closure – (see section 8 on page 9)

7.8 These meetings can be managed in a number of ways, but the key is to ensure that the correct people are involved. Sometimes it will be appropriate to meet first without the provider to ensure that all information is shared, and the provider is not overwhelmed by this. A smaller group would then meet immediately afterwards to talk the provider through the concerns. It is essential that commissioners are involved in both these meetings. The aim would be for subsequent meetings to be of all parties.

7.9 It is essential that all participants are aware that meetings are confidential and minutes will be taken. Minutes and communications about Organisational Safeguarding Enquiries must be carried out securely, in line with information governance policies.

8 ORGANISATIONAL SAFEGUARDING CLOSURE

8.1 The decision to end the Organisational Safeguarding Enquiry should be agreed by the whole meeting membership. It is therefore essential that key agencies remain involved in the safeguarding process. The multi-agency meeting will need to be satisfied that:

- all required safeguarding actions have been undertaken;
- there is evidence of a reduction in risk
- victims/involved adults have received feedback
- any necessary notifications to regulatory bodies e.g. Disclosure and Barring Agency, Nursing and Midwifery Council, have been undertaken
- any necessary referrals to the Positions of Trust Lead (PIPOT) or the Local Authority Designated Officer (LADO) have been made
- any remaining concerns can and will be managed through contract monitoring, care management processes etc
- lessons learned have been identified and taken forward

8.3 Where there is disagreement about the process of the organisational safeguarding enquiry or its closure, then these should be resolved using the SSAB Resolving Professional Differences June 2025

8.4 The Service Director, Adult Social Care, all placing commissioning bodies and CQC should be notified of the safeguarding closure once confirmed.

9 PUBLICITY AND MEDIA

9.1 Public and media interest may arise in Organisational Abuse Enquiries. Please refer to local policies and procedures in relation to the involvement of the media, however in general individual professionals should not respond directly to enquiries from the media but refer them to the Local Authority communications team, as the lead agency for the Enquiry. Co-ordination with other organisations' communication teams may also be necessary, and this should be supported/facilitated by the Local Authority communications team.

EARLY INDICATORS OF CONCERN IN CARE SERVICES CHECKLIST

It is important to note that this is not a definitive checklist. Other indicators may be identified that do not appear on this list. Equally, abuse can happen when indicators of concern are not present.

These indicators have been written to apply to all services that work with adults who have care and support needs. Not every indicator will 'fit' every type of service and practitioners should consider the nature of the service when referring to this list.

1 CONCERNS ABOUT MANAGEMENT AND LEADERSHIP

The manager of the service

- The manager leaves suddenly and unexpectedly
- The service has not had a registered manager in post over an extended period
- Arrangements to cover the service while the manager is away, are not working well
- The manager is new and doesn't appear to understand what the service is set up to do
- A responsible manager is not apparent or available within the service and has little involvement with the people receiving support
- The manager leaves staff to get on with things with little active guidance or modelling of good practice
- The manager is very controlling

Management Culture

- The service is not being managed in a planned way, but reacts to problems and crises
- The service does not respond appropriately when a serious incident has taken place
- The service fails to learn from previous incidents and does not appear to be taking steps to reduce the risk of a similar incident happening again
- Policies, procedures and practice guidance including the organisations whistle-blowing policy are absent or inadequate

The management team

- Senior staff have been in post a long time and have a high level of authority and entrenched views
- There is a high turnover of managers
- The service is experiencing difficulty in recruiting and appointing managers
- There is a lack of leadership by managers, for example managers do not make decisions and set priorities
- Managers appear unaware of serious problems in the service
- Managers do not appear to be attending to risk assessments or are not ensuring that risk assessments have been carried out properly
- Managers do not appear to have ensured that staff have information about individual people's needs and potential risks to them
- Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through
- There is a lack of effective monitoring by senior staff, including support to night staff and checks on them
- The managers know what outcomes should be delivered for people, but appear unable to organise the service to deliver these, i.e. they appear unable to 'make it happen'

Staffing

- Staff who raise issues are not listened to
- Staff are not being deployed effectively to meet the needs of people who use the service
- There is a high turnover of staff
- Staff are working long hours
- Staff are working when they are ill
- There is poor staff morale
- Recruitment processes are inadequate
- The service employs high numbers of family / friends
- There is a failure to identify concerning behaviour by staff e.g. stressed staff behaving unusually, growth of cliques, failure to work to best practice, cutting corners
- The managers have low expectations of the staff
- Staff have poor pay and conditions of employment

2 CONCERNS ABOUT STAFF SKILLS, KNOWLEDGE AND PRACTICE SUPERVISION AND TRAINING

- Staff receive little / no supervision, appraisals or opportunities for development
- Induction processes are inadequate
- Poor quality or no training is provided
- Staff appear to lack the information, knowledge and skills needed to support the people the service is set up to support
- Staff lack training in how to use equipment

Recording

- Record keeping by staff is poor
- Staff do not appear to see keeping records as important
- Risk assessments are not completed or are of poor quality, for example, they lack details or do not identify significant risks
- Care plans are not individual to the person they relate to and do not promote their needs, wishes or preferences
- Incident reports are not being completed
- Records are value laden and judgemental

Mental capacity and DOLS

- There is non-adherence to the principles of the Mental Capacity Act
- People are not supported to make choices/empowered to make decisions about their lives
- There is a lack of understanding of DOLS or the proposed legislative changes to the Liberty Protection Safeguards (LPS)
- DOLS / LPS referrals are not being made, resulting in people being unlawfully deprived of their liberty

Interactions with Adults

- Staff appear challenged by some people's behaviours and do not manage these in a safe, professional or dignified way
- Staff perceive the behaviours of people as a problem, and blame them
- Staff blame people's medical condition for all their difficulties, needs and behaviours; other explanations do not appear to be considered
- People are punished for behaviours seen to be inappropriate
- Staff treat people roughly or forcefully
- Staff ignore people
- Staff are impatient with people
- Staff talk to people in ways which are derogatory / not complimentary
- Staff shout or swear at people

- Staff do not alter their communication style to meet individual needs, for example, they speak to people as if they are children, they 'jolly people along'
- Staff use negative or judgemental language when talking about people
- Staff do not see people as individuals and do not appear aware of their life history
- Staff do not ensure privacy for people when providing personal care
- Staff tell people to use their incontinence pads rather than assist them to use the toilet

Culture

- There is a particular group of staff who strongly influence how things happen in the home
- Staff informally complain about the managers to visiting professionals
- Staff appear to lack interest and commitment
- Staff appear to lack concern for the people using the service
- Staff appear unable to relate to a particular person
- Staff are complacent about the quality of care they provide and appear defensive when challenged

3 CONCERNS ABOUT PEOPLES' BEHAVIOURS AND WELLBEING INDIVIDUALS

- Show signs of injury due to lack of care or attention, e.g. through not using wheelchairs carefully or properly, or the development of pressure injuries due to lack of or inappropriate use of pressure relieving equipment
- Appear frightened or show signs of fear
- Behaviours or appearances have changed, for example they have become unkempt or are no longer taking pride or interest in their appearance
- Moods or psychological presentation have changed
- Behaviour is different with certain members of staff/when certain members of staff are away
- Engage in inappropriate sexualised behaviours
- Do not progress as would be expected
- Experience sensory deprivation, for example, going without spectacles or hearing aids
- Experience restricted mobility by being denied access to mobility aids
- Experience restricted access to toilet / bathing facilities
- Lack personal clothing and / or possessions

General Service concerns

- The overall atmosphere is flat, gloomy or miserable
- There is a high number of low level incidents such as medication errors or falls
- There is a high number of incidents between people who use the service
- There are a high number of upheld complaints about the service
- There is evidence of inappropriate restraint methods or misused restraint, including the inappropriate use of medication
- The care regime exhibits lack of choice, flexibility and control
- The care regime appears impersonal and lacks respect for individual's privacy and dignity
- The service does not adhere to local/national guidance, for example in a pandemic

4 CONCERNS ABOUT THE SERVICE RESISTING THE INVOLVEMENT OF EXTERNAL PEOPLE AND ISOLATING INDIVIDUALS INFORMATION SHARING

- The service has few visitors/minimal outside contacts
- The service does not report safeguarding concerns
- The service does not communicate with, or report concerns to external practitioners and agencies
- The service does not liaise with families and ignores their offers of help and support
- Managers and / or staff do not respond to advice or guidance from practitioners and families who visit the service
- Managers do not appear to provide staff with information about people from meetings with external people, for example reviews
- Staff or managers appear defensive or hostile and concerned to avoid blame when questions or problems are raised by external practitioners or families
- Managers or staff give inconsistent responses or accounts of situations

Staff

- Staff work alone on a one to one basis with adults
- Staff work in silos e.g. night staff who never work days
- Staff are hostile towards or ignore practitioners and families who visit the service

People who use the service

- There are people who have little contact with others from outside the service

- There are people who are not receiving active monitoring or reviews, e.g. people who are self-funding
- People are kept isolated in their rooms and are unable to move to other parts of the building or outside independently ('enforced isolation')
- People have little or restricted access to meaningful occupation or activity inside or outside of the environment
- People have restricted access to visitors or phone calls
- People have restricted access to health or social care services

5 CONCERNS ABOUT THE WAY SERVICES ARE PLANNED AND DELIVERED THE NATURE OF THE SERVICE

- The service does not have a clear philosophy / purpose
- The service does not appear able to deliver the service or support it is commissioned to provide. For example it is unable to deliver effective support to people with distressed or aggressive behaviour
- Decisions about what service is commissioned for an individual are influenced by a lack of suitable alternatives
- The service is accepting people whose needs and / or behaviours are different to those of people previously or usually accepted
- The service is accepting people whose needs they appear unable to meet
- Peoples' needs as identified in assessments, care plans or risk assessments are not being met. For example they are not being supported to attend specific activities or provided with specific support to enable them to remain safe

Person-centred care

- Staff are task focussed and not providing person-centred care
- People are treated en-masse
- The service follows strict, regimented routines, for mealtimes, bedtimes, etc
- People lack choice about food and drink, dress, possessions, activities and where they want to spend their time
- Members of staff are controlling of people who use the

Resources

- There is a failure to provide and/or maintain correct moving and handling and other equipment such as pressure relieving mattresses
- The service is under resourced, whether staff, equipment or provisions
- There appears to be insufficient staff to support people appropriately

Audits

- There is a lack of audits of practice and process
- There is a failure to follow up on issues raised by audits
- There is a failure to monitor the use of call bells including checking they have not been disabled, especially at night

6 CONCERNS ABOUT THE QUALITY OF BASIC CARE AND THE ENVIRONMENT PERSON-CENTRED CARE

- There is a lack of privacy, dignity and respect for people as individuals
- There is a lack of provision for dress, diet or religious observance in accordance with people's individual beliefs or cultural backgrounds
- People do not have as much money as would be expected
- People lack basic things such as clothes, toiletries
- Support for people to maintain personal hygiene and cleanliness is poor and they appear unkempt
- People are not getting the support they need with eating and drinking, or are not getting enough to eat or drink
- There is poor or inadequate support for people who have health problems or who need medical attention
- Staff are not checking that people are safe and well
- There are a lack of activities or social opportunities
- There is a lack of care for people's property and clothing

Resources

- There appear to be insufficient staff to meet people's needs
- The service does not have the equipment needed to support people and keep them safe
- Equipment or furniture is broken
- Equipment is not being used or is not being used safely and correctly

Environment

- The service is not providing a safe environment
- The environment is not personalised to the people who live there, lacking photographs and personal items
- People are not supported to have a say in how the environment is decorated / furnished
- The environment is dirty and shows signs of poor hygiene
- The quality of the environment has deteriorated noticeably