When to consider raising a safeguarding concern following a Service User to Service User Incident

It is important that this guidance is read in full to support decision making

1) Service User to Service User Incidents and safeguarding

All service user to service user incidents must be recorded and reported using the appropriate procedures but not all service user to service user incidents will be safeguarding concerns.

- A degree of conflict on occasions is to be expected in all relationships, this equally applies to environments where people with care and support needs live together. There may be times when the actions of one individual toward another goes beyond usual conflict and their behaviour is abusive, causing harm, and requires a safeguarding concern to be raised.
- The purpose of this information is to provide guidance to regulated care providers on the management of service user incidents and determining when the circumstances should be considered as requiring a safeguarding concern to be raised.

What is a service user to service user incident?

- A service user to service user incident can be defined as any interaction involving 2 or more service users in any setting, involving physical, psychological/emotional, sexual, financial/material or discriminatory behaviour (including verbal and threatening), which results in the risk of, or actual harm.
- Not all service user to service user incidents will result in a safeguarding concern, but all such incidents will require some form of action from regulated care providers.

2) Responsibilities of Regulated care providers

- Preventing service user to service user incidents from occurring is always the preferred approach. Those in receipt of services should expect to be supported or cared for in a safe environment. Abuse by other service users is as harmful as any form of abuse no matter who the person causing the harm. Services should ensure that interventions and support arrangements are in place to minimise the risk of abuse from service users to other service users.

3) Best practice for the management of service user to service user incidents

- Having robust and comprehensive pre-admission assessment arrangements to establish an individual's previous and current needs. Including consideration to relationships, vulnerability and bullying.
- Considering the potential impact, where appropriate, on existing service users prior to placement, and keeping the compatibility of all service users under continuous review.
- The inclusion of anti-bullying, issues of inappropriate interactions between service users, and also between staff and service users, included in relevant policies and procedures.
- Promoting a positive culture of mutual respect where individual rights and responsibilities are discussed with service users, the MCA principles of least restrictive practice are followed and confirmed in care plans.
  Refer to DoH website: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Understanding how best to support both the individual and the person alleged to have caused the harm through assessment of needs and risk, mitigating the risks to both, and knowing the resources to access to provide the support to do this.
- Care and safeguarding plans directing staff on how to ensure the safety of vulnerable service users.
- Having measures in place to positively support those with known behavioural problems to maximise their life opportunities. This may include referral to appropriate behavioural support teams.
- Members of staff having appropriate training and knowing how to identify, record and review service user incidents.
- Staffing levels being sufficient to meet the assessed needs of the service users, and appropriate deployment of staff at the right times.
- Following the agency's notification procedures, including, where appropriate, informing the service user's family or nominated representative.
- Where there are unresolved compatibility issues, consider the need to review and refer to the commissioning body.
- Measures being in place to ensure the safety of individuals within or visiting the service.

4) Post incident Review

- When a service user incident occurs, the details should be recorded to identify any potential patterns. The information as a minimum, should include the incident date and time, the individuals involved, members of staff on duty, the circumstance immediately prior to the incident and other relevant information.
- Reviews of risk assessments and care plans should always be undertaken following each incident.
- Senior managers should review post incident information on a regular basis to determine whether or not certain individuals are frequently involved, either as the adult at risk or the alleged to have caused harm to others, and the staff on duty at the time. Reviews should consider lessons learnt, whether the incident could have been prevented, and the need for changes to avoid similar incidents recurring. The post incident findings may also trigger the need for a further review and updating of the service user risk assessments and/or a safeguarding concern being raised.

The CQC, as part of the inspection process, will require written evidence to confirm that internal reviews, including subsequent actions, have taken place following each service user incident.

Raising a Safeguarding Concern Following a Service User to Service User Incident

Under the Care Act 2014*, agencies have a legal responsibility to raise safeguarding concerns where there is **a suspicion that abuse** of a vulnerable adult has occurred which may be as a result of neglect or omission of care. This is supplementary to the requirements set out above around the management of service user incidents.

**'Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action'.*

1) Raising a safeguarding concern following a service user incident

Some examples of service user to service user incidents (not exhaustive) which **must** be considered appropriate for raising a safeguarding concern (These may be isolated or persistent incidents which have resulted in harm):-

a) Physical assault leading to significant harm or death†
b) Predictable and preventable (by staff) incident between service users resulting in some or significant harm
c) Bullying or persistent teasing resulting in distress, loss of confidence or dignity
d) Intimate touching without valid consent or verbal sexualised harassment/teasing
e) Repeated incidents/patterns of similar concern which the provider has failed to manage resulting in harm.

† Where physical harm has occurred providers should first seek emergency medical intervention, and take all necessary actions taken to respond to incidents of serious harm to ensure the immediate safety of those involved.

Systemic failings

Where there are systemic failings in a regulated providers care management which leads to repeated service user to service user incidents, services should be referred to safeguarding under organisational abuse. E.g. where best practice guidance (detailed above) has not been implemented or has not been followed.

Criminal Acts

- Alongside safeguarding adult procedures, service users have the same rights to justice and the protection of the law as any other individual. Where a crime is suspected, it should always be reported to the police preferably with the consent of the individual who has come to harm.
- A crime may also need to be reported without the person's consent, where there is a duty to report the crime and/or it is assessed as in the person's best interest in line with the Mental Capacity Act 2005.
- Service user incidents, where a crime is suspected, and the person alleged to have caused the harm lacks capacity, should still be reported to the police. It is for the police to consider the mitigating factors and determine whether a criminal investigation is the appropriate course of action.

2) When a Safeguarding Concern Does Not Need To Be Raised

If the service user to service user incident has been an isolated incident, has not caused harm and has been dealt with promptly, it may not require a safeguarding concern to be raised.

- When a safeguarding concern is not raised providers should still complete incident reports, review support plans and risk assessments for both the individual and the person alleged to have caused the harm, and take actions to

minimise the risk of recurrence. Consideration should always be given to the frequency and the impact of each incident.

- A referral to Adult Social Care, or an appropriate health care professional, should be made in response to a decline or change in service user presentation.
- The provider's usual incident notification reporting requirements should always be followed even when a safeguarding concern is not raised.
- Injuries to staff as a result of a service user incident should not be reported to safeguarding, the providers internal staff incident reporting procedures should be followed.

Some examples of service user to service user incidents where a safeguarding concern is not the appropriate response:

a) Threats being made, nothing happened and the service user is not aware of the threat.
b) Isolated incident of a service user tapping or slapping another but not with sufficient force to cause a mark or bruise, and the individual is not intimidated.
c) Isolated incident of a service user being teased or spoken to in a rude, insulting, belittling or other inappropriate way by another service user. Respect for them and their dignity is not maintained but they are not distressed.
d) Service user borrowing items from another service user with consent, and not returning these.
e) Isolated incident of teasing or low level unwanted attention (verbal or non-intimate touching) directed at one service users by another, whether or not they have mental capacity. The person is not distressed or intimidated.

This document is intended as a guidance tool, and should be used in conjunction with professional judgement. When there is any doubt as to whether to raise a safeguarding concern, staff should always speak to the safeguarding lead in their organisation, and if further advice is required to the local authority safeguarding team via the Customer Access Service safeguarding line: 0300 123 6721.

Links to guidance Information:
Department of Health – Mental Capacity Act Code of Practice https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
NICE Guidance – Short term management of violence and aggression in mental health settings https://www.nice.org.uk/guidance/ng10
NICE guidance – Challenging behaviour and learning disabilities https://www.nice.org.uk/guidance/ng11
Department of Health – Positive and Proactive Care – reducing the need for restrictive interventions https://www.gov.uk/government/publications/positive-and-proactive-care-reducing-restrictive-interventions
Dementia UK – Life Story Work https://www.dementiauk.org/for-healthcare-professionals/free-resources/life-story-work/
SCIE Resources and Services: Challenging Behaviour http://www.scie.org.uk/atoz/?f_az_subject_thesaurus_terms_s=challenging+behaviour&st=atoz
Tools and Resources: Provided by the Care Home Support Team

Service User Incident Recording Chart	**PINCH ME Checklist**
 Service User Incident Recording	 PINCH ME.docx