ASC safeguarding practice peer audit outcome report

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ASC peer audit of safeguarding practice – November 2019
Theme: Psychological Abuse

Audit sample

A sample of 24 completed enquiries categorised as involving psychological abuse were identified from across the neighbourhood teams, A&R, CLDS, hospital teams and CYPDS.
All managers in adult social care were asked to audit one case each from a different team, using adult safeguarding practice audit tool version 4.
A total of 12 completed audits were returned.

Audit outcome summary

Overall grading of the 12 audits returned:

- 8 cases were graded as standards met
- 4 cases were graded as standards partially met
- 0 cases were graded as standards not met
- 1 case was recommended as an example of good practice

Of the practice areas covered by the audit:

1. Initial safety and risk assessment: 7 out of 12 met standards
2. Consent and information sharing: 3 out of 12 met standards
3. Appropriate application of MCA: 4 out of 12 met standards
4. Involvement of service user and/or NOK: 12 out of 12 met standards
5. Making Safeguarding Personal: 9 out of 12 met standards
6. Timely and proportionate action and risk assessment/management: 7 out of 12 met standards
7. Identification of social isolation and response: 7 out of 12 identified social isolation as a factor, 6 out of these 7 met standards in their response to this.
8. Multi-disciplinary working: 10 out of 12 met standards
9. Quality of care issues highlighted and referred: 4 out of 12 cases identified quality concerns, all 4 met standards in their response.
10. SAM involvement and oversight: 6 out of 12 met standards
11. Application of principles of safeguarding: 9 out of 12 met standards.
12. Rationale for conclusion and closure: 9 out of 12 met standards
13. Overall quality of recording: 10 out of 12 met standards.

Audit findings

The theme of this audit was psychological abuse. Concerns about psychological abuse in this sample were raised by a variety of sources, including day centre and home care providers, family members, Solace and SAMH but most came from the police (3) and hospital staff (3). The sample also indicated that psychological abuse is seldom a stand-alone concern and is often closely linked with other forms of abuse. In the sample audited it was most frequently found alongside concerns about financial abuse and neglect/self-neglect. This underlines the importance of identifying multiple and

interlinked (or primary and secondary) types of abuse, as identified by the previous audit of completed enquiries, to support a more comprehensive analysis of risks and risk management action. One auditor also highlighted that categorisation solely as psychological abuse may impact on the analysis of trends where there are clearly additional risk factors being addressed in enquiries.

From the enquiries audited, the areas of practice identified as strongest were around the involvement of the service user and family, multi-disciplinary working and the quality of recording. Practice standards were also more likely to be met in the areas of MSP, application of the statutory safeguarding principles and rationale for conclusion and closure. The areas of practice that require most improvement concerned information sharing and consent, and application of MCA. Practice also needs to be strengthened around thorough risk assessment and SAM involvement and oversight.

Involving service users and Making Safeguarding Personal
This audit sample identified that there is good practice around involving service users and their families in safeguarding enquiries and seeking to work in a person-centred way. Where the service user was unable to express views, family or NOK were involved instead. There were several examples of particularly good practice where auditors highlighted how the person and their wishes were kept at the centre of the process and how the voice of the service user was captured and recorded throughout.
However, in reviewing the completed audits, it was noted that in two enquiries the family's views were sought rather than the service user's as they were considered to lack capacity, despite this not being assessed separately. In addition to never assuming a lack of capacity without formal assessment, it should not be assumed that those who lack capacity are unable to express any views and wishes. These should still be captured and documented where possible, in line with best interests decision-making and in keeping with making safeguarding personal. Additionally it was noted that in one of these enquiries, the family member consulted and representing the service user's views was also the person alleged to have caused harm, and an advocate should clearly have been used.

Multi-disciplinary working
This was another area where good practice was generally identified in the audit and the sample demonstrated practitioners working with a wide variety of other professionals and services, and involving them appropriately in safeguarding. It was particularly helpful when details of other professionals or services involved were detailed in the audit to evidence this. In areas identified for improvement by auditors, it was noted that there were sometimes missed opportunities to involve other professionals or in including all the relevant professionals or services who could contribute to the enquiry to ensure holistic information gathering and a comprehensive assessment and shared plan. It was, however, also noted that safeguarding processes were sometimes affected by the poor knowledge and practice of other professionals, and suggested that other partners, notably health staff, may require more training, in particular around making safeguarding personal and proportionate responses, as well as further MCA/DoLS training.

Information sharing and consent and application of Mental Capacity Act
These were the areas of practice identified in this audit sample as most requiring improvement. The sample highlighted concerns that formal mental capacity assessments are not always being completed where it has been indicated that there are concerns about capacity or it is thought that the person lacks capacity. The importance of formal capacity assessments was strongly emphasised by auditors as an area for improvement, and the importance of these being embedded in the workflow, rather than in uploaded word documents or case notes, was also highlighted as they need to be easy to identify, especially when they relate to significant decisions. An assumption of a lack of

capacity without a formal assessment, in addition to directly contravening the Mental Capacity Act, appeared to sometimes be the justification for not seeking consent or for not involving a service user in the process or seeking their views. In these instances, NOK or family were usually involved to represent them but it is important to reiterate that capacity must be assumed and where this is questioned it must be assessed formally. As identified in practice around service user involvement and MSP, a lack of capacity also does not mean a person cannot still express wishes and views. This also indicates the need for increased consideration of advocacy, as recommended by the previous enquiries audit. In this audit sample, the use of advocacy was referenced in four of the enquiries, but a further two identified that advocacy should have been utilised as part of the process.
Where auditors had identified good practice in relation to information sharing, consent and MCA, they described this as clear recording on decisions and actions in these areas, as well as the formal workflow being completed, so that the rationale and decisions were clear to auditors. The importance of making sure copies of documents are uploaded, such as capacity assessments completed by other services, was also highlighted.

Risk assessment and evidence of SAM involvement
The audit results identified risk assessment as being another area where practice could be improved, as just over half of the sampled cases met the standards in this area. The areas for improvement highlighted by auditors included outlining the potential impact of risks and providing more analysis of risks, including what is being done to address them. Two audits noted that while good initial risk assessment was done at the concern stage, this was less clear in the enquiry. One audited case had no or limited risk assessment throughout. Where good practice was highlighted, proportionality was a common theme. Opportunities were sometimes missed to seek the views of wider family members, and also other professionals, such as GPs, which would have contributed to more comprehensive risk assessment and management. One auditor also noted the importance of considering the mental state of the PACH, for example, where abuse may be as a result of possible undiagnosed mental health problem, and documenting any action taken around this, as this could be key to future prevention and longer term resolution of the concerns. This is also relevant to appropriate application of MCA as the PACH's capacity should be explored.

With respect to evidencing SAM involvement, auditors indicated that more case note recordings were needed to demonstrate SAM oversight, case direction and supervision, which might also ensure agreed actions re followed up. Other areas identified for improvement were where the manager's notes were felt to be too brief and sections for manager's comment and lessons learned were not completed in the workflow, as well as delays in signing off or progressing workflows. It was suggested that planning meetings can be useful in retaining a record of discussion of ongoing issues, new incidents and risks with SAM oversight.
Examples of good practice were described as clear SAM input in both the workflow, meetings and minutes, and clear oversight or case guidance provided in case notes. A possible issue highlighted, that may impact on aspects of recording, was when the enquiry officer's manager and SAM may not be the same person, in terms of supervision case notes.

Identification of social isolation and quality concerns
Where social isolation was identified, the auditors felt that standards were generally met. There was one example of particularly good practice where socially isolating the service user formed part of the concern and this was actively addressed as part of the protection plan. In another enquiry concerning financial abuse by a friend, the auditor identified that social isolation was noted as a key focus of the safeguarding process but could have been explored further to reduce this risk. There were also two other cases where social isolation was not considered to be an issue but the nature of the concerns raised suggested this could have been explored further as a potential factor. This suggests there may still be missed opportunities to consider the impact of social isolation on

vulnerability to abuse and how addressing this may reduce the risk, with a view to the principles of empowerment, protection and prevention. This might be particularly relevant to vulnerability to psychological abuse, coercion and control, undue influence and related financial abuse or neglect. Quality concerns were reported to have appropriately addressed in the sample reviewed by this audit. However, in reviewing the completed audits it was noted that one enquiry related to the conduct of a hospital worker and this audit was not flagged as containing a quality alert, so how this was addressed was not captured.

Recommendations

- People cannot be assumed to lack capacity and so this must be evidenced by a formal capacity assessment being completed where this is alleged. This must also be completed in the appropriate workflow so this can be easily identified and copies of any external capacity assessment referenced must be uploaded.
- Consent must be sought or a clear documentation of why this was not possible and the decisions and actions taken. If a person lacks capacity to give consent this must be evidenced.
- The views and wishes of people of people who lack capacity should still be sought and documented where they can express them. These should be captured from the very start of the safeguarding process and revisited throughout as part of making safeguarding personal. Formal advocacy must be considered where applicable.
- The mental state and capacity of the PACH should be explored, where relevant, and any action around this clearly recorded.
- Wider networks of professionals, services or family involved with a service user should be considered where appropriate and proportionate for enhanced information gathering and shared risk assessment and planning, not just those immediately involved.
- Risk assessment should include an analysis of the risks and their potential impact, and what is being done to mitigate these, and should be clearly documented in both the concern and the enquiry stages.
- SAMs should ensure they complete the manager's comment and checklist in section 12 of the enquiry workflow, lessons learned where applicable when an enquiry has been concluded, and evidence their case oversight and direction in case notes.
- The potential impact of social isolation on vulnerability to psychological abuse and interconnected forms of abuse should always be considered, including and perhaps especially where the concerns involve apparent friends or family.
- Quality concerns extend to anyone employed by a service providing care to vulnerable people, such as hospital workers. This should be escalated with the relevant quality assurance body regulating that service or provider.