Poor Practice

These are just examples and it is important that each case is assessed on its own merits by provider managers/commissioners/practitioners to determine whether the concern is poor practice or abuse which requires a response under safeguarding procedures.

	Poor practice which requires actions by provider agencies, e.g. care/nursing homes, hospital wards or domiciliary care agencies, day services, etc.	Possible abuse which requires a response using Safeguarding Procedures
1	Patient/service user does not receive necessary help to have a drink/meal and no significant harm has occurred to the person or others. If this is an isolated incident and a reasonable explanation is given - e.g. unplanned staffing problem, emergency occurring elsewhere in the home - and the incident is dealt with using internal procedures, this would not be referred under Safeguarding Adults Procedures.	Patient/service user does not receive necessary help to have drink/meal and this is a recurring event, or is happening to more than one vulnerable adult. This constitutes neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation.
2	Patient/service user does not receive necessary help to get to toilet to maintain continence or have appropriate assistance such as changed incontinence pads. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home and is dealt with in a timely way through internal procedures/processes, this would not be referred under Safeguarding Adults Procedures.	Patient/service user does not receive necessary help to get to the toilet to maintain continence and this is a recurring event, or is happening to more than one vulnerable adult. Neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation.
3	Patient/service user has not been formally assessed with respect of pressure area management but no discernible harm has arisen. This is an isolated incident; action has been taken to address the pressure area management. This may need to be dealt with under different processes, i.e. disciplinary procedures.	Patient/service user is frail and has been admitted without formal assessment with respect of pressure area management. Care provided with no reference to specialist advice re: diet, care or equipment. Pressure damage occurs. Neglectful practice, breach of regulations and contract, possible institutional abuse. Safeguarding procedures should be instigated.

4	Patient/service user does not receive medication as prescribed on one occasion, but no harm occurs. GP advised/action taken, internal investigation is undertaken, possible disciplinary action depending on severity of situation.	Patient/service user does not receive medication as a recurring event, or this is happening to more than one vulnerable adult. Neglectful practice, regulatory breach, breach of professional code of conduct if nursing care provided. Dependent on degree of harm, possible criminal offence. Safeguarding procedures should be instigated.
5	Appropriate moving and handling procedures not followed but patient/service user does not experience harm. Provider acknowledges departure from procedures and inappropriate practice and deals with this appropriately, for example, under disciplinary procedures, staff training provided, to the satisfaction of the service user, care plan is revised.	One or more service users experience harm through failure to follow correct moving and handling procedures, or common flouting of moving and handling procedures make this likely to happen. Neglectful practice. Safeguarding procedures should be instigated.
6	Patient/service user is spoken to in a rude, insulting, belittling or other inappropriate way by a member of staff. They are not distressed by the incident and this is an isolated occurrence. Provider takes appropriate action, for example, supervision, training, disciplinary, and to the satisfaction of the service user.	Patient/service user is frequently spoken to in a rude, insulting or belittling way or other inappropriate way or it is happening to more than one vulnerable adult. Regime in the home does not respect dignity of service users and staff frequently use derogatory terms and are abusive to service users. Regulatory breach. Safeguarding procedures should be instigated.
7	Service user does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs. Provider deals with this via appropriate responses for example, commissioners notified, internal investigation, complaints procedures, care management review, to the satisfaction of the service user.	Service user does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being, resulting in harm or potentially serious risks to service user. Safeguarding procedures should be instigated.
8	Patient/service user has a fall. The adult is being supported to remain active; a falls assessment has been completed and is reflected in the care plan. A capacity assessment is in place if there is reason to be concerned that the adult does not have	Patient/services user has a fall, the risks of falls are known but the risks had not been assessed. The service does not have in place a falls prevention strategy, staff have not had training.

	capacity to assess the risks to themselves. Appropriate aids and equipment to reduce falls are provided. Appropriate referrals to community health professionals are in place.	The patient/service user does not have the capacity to assess the risks to themselves, and no assessment of capacity has been undertaken. Restrictions or restraints are used and not reflected in risk assessments, care plans, capacity assessments, best interest decisions or use of DoLS where appropriate.

Adapted from Dyfed Powys Policies and Procedures 2007