Newcastle Safeguarding Adults Board

Safeguarding Adults and Medicines related incidents

Deciding whether to refer a medicines related incident to the Safeguarding Adults Procedures.

If you are in any doubt whether a concern constitutes a safeguarding matter, then you should contact the Local Authority in your area:
www.safeguardingadultsne.co.uk

Contents

Foreword

A working group was established in March 2010 in response to the Newcastle Safeguarding Adult Board to write a protocol/guidance to assist staff in deciding when a medicines related incident is a safeguarding issue.

The remit was to define what is meant by a medicines related incident with the aim of establishing a standard approach to consider when an incident / error involving medication should be referred to safeguarding services. The document should be able to be utilised by the wide diversity of services that may be involved in the initial identification of an incident such both in primary and secondary care settings such as;

- Intermediate care settings such as resource centres
- Community based services such as care at home services, district nurses
- GP practices
- Hospital wards and department (Acute services and mental health services)
- Care Quality Commission inspectors
- Others

Representatives from a wide variety of heath and social care setting were approached to contribute to the working group. Initially, these people were from Newcastle and North Tyneside based services, but later there were requests from representatives in Northumberland services to be included in the discussions.

Date of Issue	December 2011
Review Date	December 2012, July 2015

Deciding whether to refer a medicines related incident to the Safeguarding Adults Procedures

Aim of Protocol

This protocol provides guidance for staff in all sectors who are concerned that a medicines related incident (or drug errors) may have arisen as a result of poor practice, neglect or intention to cause harm and therefore have to decide whether to make a safeguarding adults referral under multi-agency policy and procedures.

Introduction

Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support, where this has resulted in, or is highly likely to result in the person experiencing severe ill health or adverse effects.

All cases of actual or suspected neglect should be referred through the safeguarding procedures where the adult at risk has consented to this OR the adult at risk has been assessed as lacking in capacity and a best interest decision has been made to make the safeguarding adults referral OR there is a reason to override consent. However, in safeguarding adults cases involving medicines related incidents there will often be a duty to override a person's consent because of risks to others – in particular where the medicines related incident has involved paid staff who may be working with a number of other adults with care and support needs.

In line with Making Safeguarding Personal principles, safeguarding adults enquiries should be driven by the desired outcomes of the person who has been harmed or who is at risk of harm wherever possible. As described above, it may not always be possible to follow these principles where a medicines related incident has involved a staff member and where there is a duty of care to other adults with care and support needs. However, views of the adult at risk (or their representative) should still be sought as part of the safeguarding adults enquiry.

Although not all poor practice is neglect, some may be. Poor practice may also need to be reported through the safeguarding procedures, to ensure areas of concern are appropriately addressed. Refer to the **Safeguarding Adults Risk Threshold** for guidance on the type of incidents/concerns that need to be referred under safeguarding adults policy and procedures.

Medicines related incidents have a number of causes, such as lack of knowledge, failure to adhere to system and protocols, interruptions, staff competency, poor handwriting and instruction, and poor communication. **(See section on definition of medicines related incidents)**

If necessary a safeguarding adults referral must then be made to Community Health and Social Care Direct or the allocated Social Worker if known or the Hospital Social Work team if the Adult at Risk in in hospital. The safeguarding adults referral should be made clearly documenting the incident, actions and outcomes in relevant case notes, by contacting one of the following:

- The relevant Adult Social Care Team Manager– when patient[1] / service user is known to Adult Social Care and has an allocated Social Worker/ Care Manager.
- The Hospital Social Work Team Manager - when patient / service user is in hospital.
- Community Health and Social Care Direct - when the alleged abuse/neglect has taken place in a care home[2] or if you are unsure who else to contact.
- Any other local organisational reporting system.

Safeguarding adults referrals do not need to be made out of hours unless there is an urgent social care need for an individual or individuals.

Staff[3] should also refer to:

- their own organisation's policies and procedures on medication management.
- other relevant local and national guidelines, protocols and policies e.g. NICE Guidance, NMC, incident reporting policies.

The National Institute for Health and Care Excellence (NICE) have produced guidelines for managing medicines in care homes: https://www.nice.org.uk/guidance/sc1

The decision as to whether there needs to be formal investigation as part of the safeguarding adults enquiry is made at the Safeguarding Adults Strategy Meeting/ Discussion. These Strategy Meetings/Discussions are convened in response to individual cases.

[1] The term "patient" is used throughout this document. However, this term also refers to residents/service users in care homes and those living in their own homes.
[2] If the alleged abuse has occurred in a care home, hospital or other registered services, the Care Quality Commission should also be notified
[3] The term "staff" is used to refer to employees from all sectors.

If you are in any doubt whether a concern constitutes a safeguarding matter, then you should contact the Local Authority in your area: www.safeguardingadultsne.co.uk

Medicines related incidents

Definitions of a Medicines related incident

"A medicines related incident is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer."[4]

The following list gives examples of scenarios where medicines related incidents can occur. Near misses in any of the sections below should also be considered. The definitions have been divided into sections according to the National Patient Safety Agency (NPSA) Safety in doses: medication safety incidences in the NHS (2007).

Based on information gathered from;

- CHUMS report http://qshc.bmj.com/content/18/5/341.full?sid=2b668dea-967a-43d7-a52e-e6d9c992110f
- CQC http://www.cqc.org.uk/newsandevents/newsstories.cfm?widCall1=customWidgets.content_view_1&cit_id=35474
- NPSA alerts; www.nrls.npsa.nhs.uk/alerts.

This is not a definitive list and as such clinicians, managers, and clinical governance managers must exercise professional judgment prior to progressing the issue.

1. Prescribing Errors
    - Patient prescribed the wrong medication / dose / route / rate.
    - Incomplete information e.g. no strength or route specified.
    - Medication omitted from prescription.
    - Medication prescribed to the wrong patient.
    - Transcription errors.
    - Prescribing without taking into account the patients clinical condition.
    - Prescribing without taking into account patients clinical parameters e.g. weight.
    - Prescription not signed.

[4] National Coordinating Council for Medicines related incident Reporting and Prevention (www.nccmerp.org)

2. Dispensing Errors
    - Patient dispensed the wrong medication / dose / route.
    - Medication dispensed to the wrong patient.
    - Patient dispensed an out of date medicine.
    - Medication is labelled incorrectly.

3. Preparation and Administration Errors
    - Patient administered the wrong medication / dose / route.
    - Patient administered an out of date medicine.
    - Medication administered to the wrong patient.
    - Medication omitted without a clinical rationale.
    - Medication incorrectly prepared.
    - Unauthorised administration i.e. disguised in food.[5]
    - Incorrect infusion rate.
    - Medication administered late / early.[6]
    - Medication deliberately not administered without good reason.
    - Administration of medication recorded incorrectly or not recorded.
    - Failure to ensure staff competence in medication administration.
    - Failure to manage changes in a person's prescribed medication

    (for example MAR charts not updated at time of transfer of care)

4. Monitoring Errors
    - Patient known to be allergic to medication but the medication was prescribed and/or dispensed and / or administered.
    - Failure to provide the patient with correct information regarding their medication e.g. when to take, what it is for, side effects.
    - Failure to monitor therapeutic levels.
    - Failure to monitor patient / carer who is self-medicating.
    - Failure to react appropriately to signs of ill health, pain, change in a person's needs or requests for help due to being un-well – associated with medication administration.

[5] There may be occasions when covert drug administration is acceptable. Nurses should follow Nursing and Midwifery Council (NMC) advice. Action must adhere to the Mental Capacity Act (2005).

[6] It is recognised that this is a complex issue and the full context of late/early administration should be taken into account. Where late / early medication administration would have a significantly detrimental effect on patient care, this constitutes an error.

5. Assessment and communication of need
    - Failure to assess/inadequate assessment of a person's needs in relation to medication.
    - Lack of communication and/or sharing of information about a person's needs and medication.

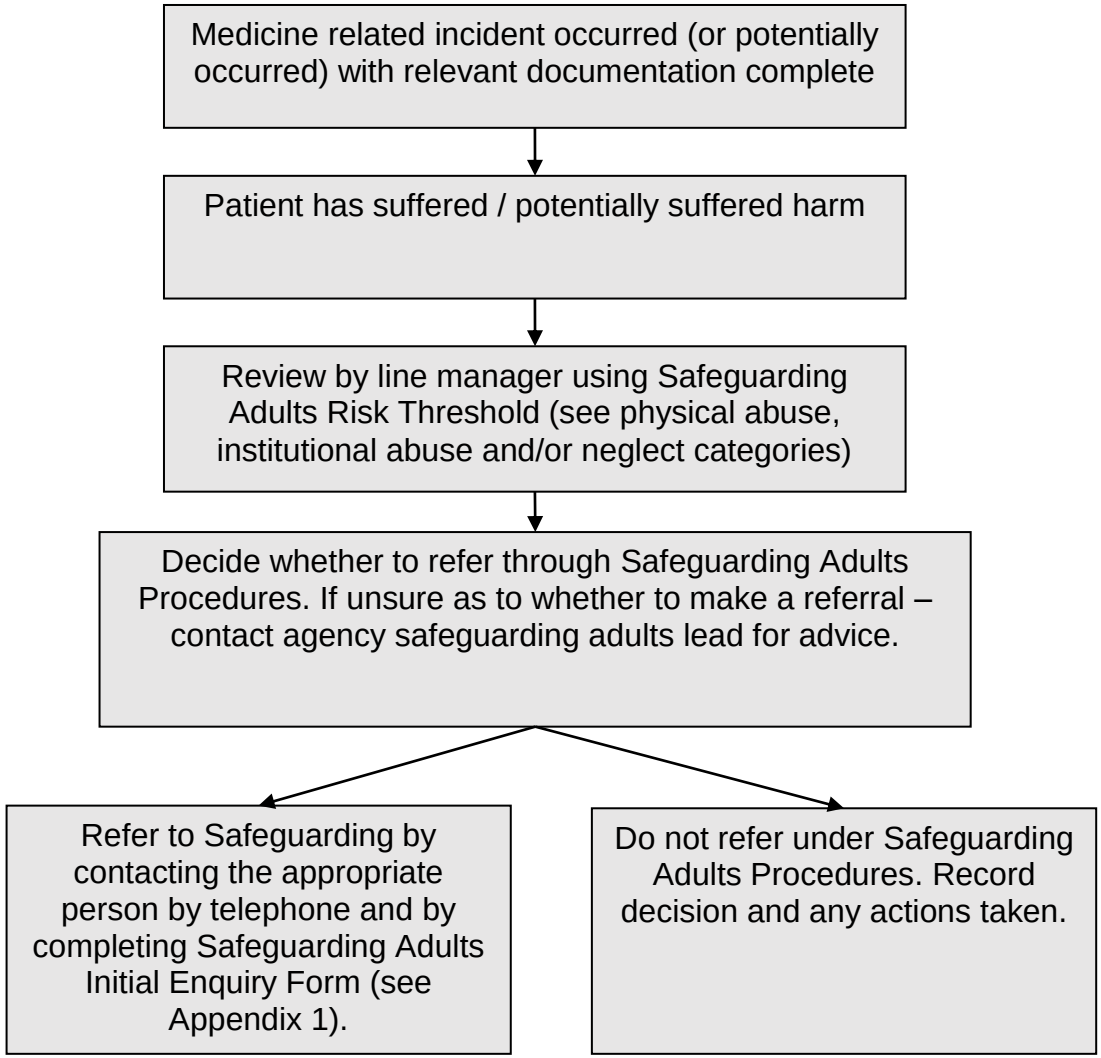
6. Other errors may include;
    - Poor or inadequate communication.
    - Poor, inadequate or incorrect recording / documentation.
    - Inappropriate or inadequate disposal of medicines.
    - Inappropriate administration of medication to chemically manage a patient's behaviour that has not been prescribed or giving additional doses to sedate patient.
    - Deviation from local policy and guidelines relating to Medicines Management.

Process

When a medicine related incident (or potential incident) leads to a referral to the Newcastle Safeguarding Adults interagency procedures.

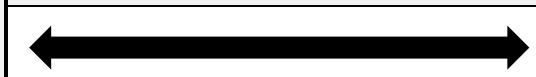
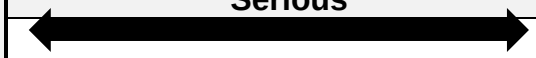
When a medicines related incident or potential incident occurs, staff should follow the standard policy, procedure and reporting systems for their organisation.

The flow chart below demonstrates the process for reaching the decision to refer to Newcastle Safeguarding Adults procedures.



If you are in any doubt whether a concern constitutes a safeguarding matter, then you should contact the Local Authority in your area: www.safeguardingadultsne.co.uk

Safeguarding Adults Risk Threshold Tool

Factors				Guidance and considerations	
1. Vulnerability of the adult at risk	**Less vulnerable**  **More vulnerable**			• Does the adult have needs for care and support? • Can the adult protect themselves? • Does the adult have the communication skills to raise an alert?	• Does the person lack mental capacity? • Is the person dependent on the alleged perpetrator? • Has the alleged victim been threatened or coerced into making decisions?
The abusive act	**Less serious**  **More Serious**			Questions 2-9 relate to the abusive act and/or the alleged perpetrator. Less serious concerns are likely to be dealt with at initial enquiry stage only, whilst the more serious concerns will progress to further stages in the safeguarding adults process.	
2. Seriousness of Abuse	Low	Significant	Critical	**Refer to the table overleaf.** Look at the relevant categories of abuse and use your knowledge of the case and your professional judgement to gauge the seriousness of concern.	
3. Patterns of abuse	Isolated incident	Recent abuse in an ongoing relationship	Repeated abuse	• Most local areas have an escalation policy in place e.g. where safeguarding adults procedures will continue if there have been a repeated number of concerns in a specific time period. Please refer to local guidance.	
4. Impact of abuse on victims	No impact	Some impact but not long-lasting	Serious long-lasting impact	• Impact of abuse does not necessarily correspond to the extent of the abuse – different people will be affected in different ways. Views of the adult at risk will be important in determining the impact of the abuse.	
5. Impact on others	No one else affected	Others indirectly affected	Others directly affected	Other people may be affected by the abuse of another adult. • Are relatives or other residents/service users are distressed or affected by the abuse? • Are other people intimidated and/or their environment affected?	
6. Intent of alleged perpetrator	Unintended/ ill-informed	Opportunistic	Deliberate/ Targeted	• Is the act/omission a violent/serious unprofessional response to difficulties in caring? • Is the act/omission planned and deliberately malicious? Is the act a breach of a professional code of conduct? ***The act/omission doesn't have to be intentional to meet safeguarding criteria**	
7. Illegality of actions	Bad practice -	Criminal act	Serious criminal	Seek advice from the Police if you are unsure if a crime has been committed. • Is the act/omission poor or bad practice (but not illegal) or is it clearly a crime?	

If you are in any doubt whether a concern constitutes a safeguarding matter, then you should contact the Local Authority in your area:
www.safeguardingadultsne.co.uk

	not illegal		act	
8. Risk of repeated abuse on victim	Unlikely to recur	Possible to recur	Likely to recur	• Is the abuse less likely to recur with significant changes e.g. training, supervision, respite, support or very likely even if changes are made and/or more support provided?
9. Risk of repeated abuse on others	Others not at risk	Possibly at risk	Others at serious risk	Are others (adults and/or children) at risk of being abused: • Very unlikely? • Less likely if significant changes are made? • This perpetrator/setting represents a threat to other vulnerable adults or children.

Types of abuse and seriousness	**Concerns may be notified to the Local Authority but these are likely to be managed at Initial Enquiry stage only. Professional judgement or concerns of repeated low level harm will progress to further stages in the safeguarding adults process.**		**Concerns of a significant or critical nature should be referred to the local authority (with consent of the alleged victim where this is relevant and appropriate to do so). They will receive additional scrutiny, and progress further, under safeguarding adults procedures. Where a criminal offence is alleged to have been committed, the Police will be contacted. Other emergency services should be contacted as required.**		
	Low		**Significant or critical**		
Physical	• Staff error causing no/little harm e.g. friction mark on skin due to ill-fitting hoist sling. • Minor events that still meet criteria for 'incident reporting' accidents. **Medication** • Adult does not receive prescribed medication (missed/wrong dose) on one occasion – no harm occurs.	• Isolated incident involving service on service user. • Inexplicable marking found on one occasion. • Minor event where users lack capacity. **Medication** • Recurring missed medication or administration errors that cause no harm.	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions. • Accumulations of minor incidents. • Recurring missed medication or errors that affect more than one adult and/or result in harm. • Deliberate maladministration of medications.	• Covert administration without proper medical authorisation. • Inappropriate restraint. • Withholding of food, drinks or aids to independence. • Inexplicable fractures/injuries. • Assault.	• Grievous bodily harm/assault with a weapon leading to irreversible damage or death. • Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death.
Sexual (including sexual exploitatio	• Isolated incident of teasing or low-level unwanted sexualised attention (verbal or	• Minimal verbal sexualised teasing or banter.	• Recurring sexualised touching or isolated or recurring masturbation without consent.	• Attempted penetration by any means (whether or not it occurs within a relationship) without consent.	• Sex in a relationship characterised by authority inequality or exploitation e.g. receiving something in return

n)	touching) directed at one adult by another whether or not capacity exists.		• Voyeurism without consent • Being subject to indecent exposure. • Grooming including via the internet and social media.	• Being made to look at pornographic material against will/where consent cannot be given.	for carrying out a sexual act. • Sex without consent (rape).
Psychological/Emotional	• Isolated incident where adult is spoken to in a rude or inappropriate way – respect is undermined but no/little distress caused.	• Occasional taunts or verbal outburst. • Withholding of information to disempower.	• Treatment that undermines dignity and esteem. • Denying or failing to recognise adult's choice or opinion.	• Humiliation. • Emotional blackmail e.g. threats or abandonment/harm. • Frequent and frightening verbal outbursts or harassment.	• Denial of basic human rights/civil liberties, over-riding advance directive. • Prolonged intimidation. • Vicious/personalised verbal attacks.
	Low		**Significant or critical**		
Financial	• Staff personally benefit from users funds e.g. accrue 'reward' points on their own store loyalty cards when shopping. • Money not recorded safely and properly.	• Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered. • Non-payment of care fees not impacting on care.	• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest. • Adult denied access to his/her own funds or possessions.	• Misuse/misappropriation of property or possessions of benefits by a person in a position of trust or control. • Personal finance removed from adult's control. • Ongoing non-payment of care fees putting a person's care at risk.	• Fraud/exploitation relating to benefits, income, property or will. • Theft.
Neglect	• Isolated missed home care visit where no harm occurs. • Adult is not assisted with a meal/drink on one occasion and no harm occurs. • Adult not bathed as often as would like – possible complaint.	• Inadequacies in care provision that lead to discomfort or inconvenience- no harm occurs e.g. being left wet occasionally. • Not having access to aids to independence.	• Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs. • Hospital discharge without adequate planning and harm occurs.	• Ongoing lack of care to the extent that health and wellbeing deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence.	• Failure to arrange access to lifesaving services or medical care. • Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk.
Self-	• Incontinence leading to	• Isolated/ occasional	• Multiple reports of concerns	• Ongoing lack of care or	• Failure to seek lifesaving

Neglect	health concerns	reports about unkempt personal appearance or property which is out of character or unusual for the person.	from multiple agencies • Behaviour which poses a fire risk to self and others • Poor management of finances leading to risks to health, wellbeing or property	behaviour to the extent that health and wellbeing deteriorate significantly e.g. pressure sores, wounds, dehydration, malnutrition	services or medical care where required. • Life in danger if intervention is not made in order to protect the individual.
Organisational (any one or combination of the other forms of abuse)	• Lack of stimulation/ opportunities for people to engage in social and leisure activities • Service users not given sufficient voice or involve in the running of the service	• Denial of individuality and opportunities for service user to make informed choice and take responsible risks • Care-planning documentation not person-centred	• Rigid/inflexible routines • Service user's dignity is undermined e.g. lack of privacy during support with intimate care needs, sharing under-clothing	• Bad/poor practice not being reported and going unchecked • Unsafe and unhygienic living environments	• Staff misusing their position of power over service users • Over-medication and/or inappropriate restraint used to manage behaviour • Widespread consistent ill-treatment
	Low		**Significant or critical**		
Discriminatory	• Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	• Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period • Occasional taunts	• Inequitable access to service provision as a result of a diversity issue. • Recurring failure to meet specific care/support needs associated with diversity.	• Being refused access to essential services. • Denial of civil liberties e.g. voting, making a complaint. • Humiliation or threats on a regular basis, recurring taunts.	• Hate crime resulting in injury/emergency medical treatment/fear for life. • Hate crime resulting in serious injury or attempted murder/honour-based violence.
Modern Slavery	All concerns about modern slavery are deemed to be of a significant/critical level.		• Limited freedom of movement. • Being forced to work for little or no payment. • Limited or no access to medical and dental care. • No access to appropriate benefits.	• Limited access to food or shelter. • Be regularly moved (trafficked) to avoid detection. • Removal of passport or ID documents.	• Sexual exploitation. • Starvation. • Organ harvesting. • No control over movement / imprisonment. • Forced marriage.
Domestic Abuse (consult Domestic Violence	• Isolated incident of abusive nature	• Occasional taunts or verbal outbursts	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions • Alleged perpetrator exhibits controlling behaviour	• Accumulations of minor incidents • Frequent verbal/physical outbursts • No access/control over finances	• Threats to kill, attempts to strangle choke or suffocate • Sex without consent (rape). • Forced marriage. • Female Genital Mutilation

and Abuse Flowchart)		• Limited access to medical and dental care	• Stalking • Relationship characterised by imbalance of power	(FGM). • Honour based violence.
	The CAADA DASH Risk Assessment Checklist should be used to determine the level of risk in domestic abuse cases and a referral made into MARAC where appropriate			

Appendix A

Further guidance on using the safeguarding adults risk threshold tool

Purpose

The safeguarding adults risk threshold tool has been developed to assist practitioners in assessing the seriousness and level of risk associated with a safeguarding adults concern. It is primarily for use by Safeguarding Adults Managers, in the Local Authority, to assist with their decision-making at the point of receiving a safeguarding adults concern; however others may find it helpful to refer to this tool when responding to a concern of abuse or neglect. The aim is to ensure that everyone understands the threshold consideration. The tool is not intended to replace professional judgement.

A clear threshold and process, together with a common understanding across local partnerships and agencies will improve consistency. A number of reasons are provided to support the need for a threshold tool. These include:

- A benchmark to assess the level of vulnerability of an individual;
- A measure of consistency;
- Managing the demand of low, significant, and critical level concerns.

Consistency

There is a need for a consistent approach to safeguarding adults. Appropriate thresholds are seen as a good way to achieve this. The safeguarding adults risk threshold is clearly explained in the multi-agency procedures and in learning and development opportunities. Practitioners are encouraged to use their professional judgement and to consider each case on an individual basis. Additional processes may need to be considered for some sections of the community who are harder to reach.

The Care Act

The Care Act statutory guidance states that:
"Local Authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult:

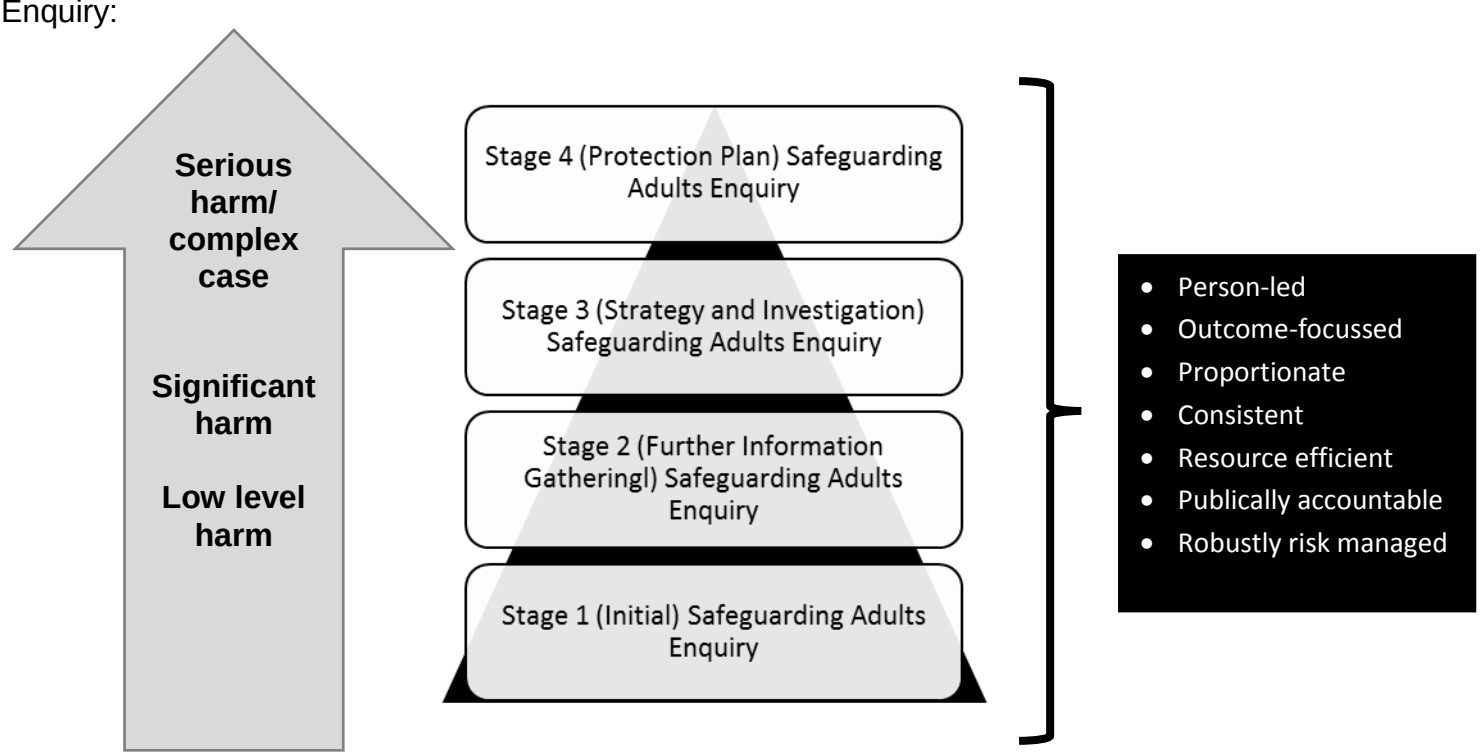
- Has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse and neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect."

There is no longer a "significant harm" threshold for action under safeguarding adults procedures. However, any actions taken must be proportionate to the level of presenting risk or harm and be driven by the desired outcomes of the adult or their representative. Referring agencies need to use their professional judgement, consider the views of the adult at risk and where appropriate, seek consent for sharing information on a multi-agency basis.

If a decision is made **not** to refer to the Local Authority, the individual agency must make a record of the concern and any action taken. Concerns should be recorded in such a way that repeated, low level harm incidents are easily identified and subsequently referred. Not referring under safeguarding adults procedures, does not negate the need to report internally or to regulators/commissioners as appropriate.

Where a concern is referred on a multi-agency basis, a Local Authority Safeguarding Adults Manager will then use the risk threshold tool to determine whether safeguarding adults procedures will continue beyond the Initial Enquiry stage.

The following diagram highlights the different stages of a Safeguarding Adults (Section 42) Enquiry:



Managing the different levels of harm
In order to manage the large volume of concerns which come under safeguarding adults policy and procedures, there is a need to differentiate between those concerns relating to low level harm/risk and those that are more serious. Whilst it is likely that concerns relating to low level harm/risk will not progress beyond an Initial Enquiry Stage, the concern will be recorded by the Local Authority and proportionate action taken to manage the risks that have been identified. This may include: provision of information or advice; referral to another agency or professional; assessment of care and support needs. The sharing of low level concerns helps the Local Authority to understand any emerging patterns or trends that may need to be taken into consideration when deciding whether safeguarding adults procedures need to continue.

Using the safeguarding adults risk threshold tool
The safeguarding adults risk threshold tool has been designed to consider both the vulnerability of the adult at risk, the seriousness of the abuse that is occurring, the impact of the abuse and the risk of it recurring.

Regular, low level concerns can amount to a far higher level of concern which then requires more in-depth investigation or assessment under safeguarding adults procedures. Each local area has an escalation policy in place to aid professional judgement in these circumstances. This means that a specified number of safeguarding adults concerns reported to the Local Authority in a

specified timeframe will result in further action under safeguarding adults procedures. Please refer to each area's policy and procedure.

The tool is not designed in way in which further actions are determined by achieving a score or a specified number of ticks. It is there to provide guidance and key considerations for practitioners who are assessing and managing risk.

Appendix 2

Safeguarding Adults Initial Enquiry Form

(formerly the SAMA1 form)

This form is to be used to notify Adult Social Care of suspected or actual instances of abuse or neglect and is the start of a Safeguarding Adults (Section 42) Enquiry under the Care Act. Details of how and who to send this form to are available on page 4. Please attach further pages if necessary.

This form should be completed as fully as possible in order that robust decisions can be made about the progression, or otherwise, of the Safeguarding Adults Enquiry.

Person completing the form:		**Role of Person:**	
Date of referral to Adult Social Care:		**Organisation:**	
Phone number:		**Type of service:**	
Details of incident/suspected/actual abuse or neglect			
Date of alleged incident:		**Who reported the alert/concern?**	
Time of alleged incident:		**Date of report:**	
Where did the incident occur?			
Details of the adult at risk			
Name:		**Date of Birth:**	
Telephone:		**Ethnicity:**	
Address:			

What is the adult's primary reason for needing care and support? (please tick)

Physical support:		**Sensory support:**		**Support with memory and cognition:**	
Learning disability support:		**Asperger's syndrome support:**		**Autism support:**	
Mental health support:		**Social support (includes support for carers/substance misusers):**		**No support reason:**	
Other health condition:		**Please specify:**			
Any other details about the adult at risk:					

Details of the alleged perpetrator (where relevant)			
Name:		**Relationship to victim:**	
Date of birth:		**Ethnicity:**	
Address:		**Telephone:**	
If the alleged perpetrator is a staff/volunteer, provide details ***(e.g. employer, job role, work address)*****:**			

Are they an adult with care and support needs?	**Yes**		**No**	
Details of care and support needs *(if applicable)*:				
Any other details about the alleged perpetrator(s):				

Description of the alleged incident/harm

Please give a detailed description of the incident (including times), all people involved, witnesses and any other comments you feel are relevant. If the concern relates to physical abuse please provide a body map.

Type of abuse (tick all that apply):

Physical		**Sexual**		**Psychological/emotional**	
Financial/material		**Neglect/omission**		**Discriminatory**	
Organisational/institutional		**Self-neglect**		**Domestic abuse/violence**	
Modern slavery		**Radicalisation/extremism**		**Other**	

If other, please specify:

Is the victim at risk of further abuse/neglect? (please tick)	**Yes**		**No**		**Unknown**	

What has been done to ensure the immediate safety of the alleged victim(s) and others? Completing and submitting this form does not constitute management of immediate risks.

Were the Police called?	**Yes**		**No**	

Please provide the outcome of the Police action and Police log number (if available):

If the incident relates to domestic abuse/violence, has the MARAC Checklist (CAADA-DASH) been completed?	**Yes**		**No**	
If yes, has a referral to MARAC been considered? Please provide details, including discussions with your agency's Single Point of Contact (SPOC) for MARAC:	**Yes**		**No**	

Please provide details of other agencies involved that will be able to help with the safeguarding adults enquiry:

Are you aware that there have there been any previous referrals	**Yes**		**No**	

made in relation to this adult at risk or alleged perpetrator?				

If yes, please provide details (e.g. dates, type of abuse, action taken):

Are there any risks to others (other adults, children)?	**Yes**		**No**		**Unknown**	

Please provide details (also include who this information has been shared with – e.g. Police, Children's Social Care, MAPPA). If there are risks to children you must notify Children's Social Care.

Involvement of the adult(s) at risk

The following section is crucial to determining the next steps in the safeguarding adults enquiry and every attempt should be made to complete it as fully as possible.

Has the adult(s) at risk given consent for this referral?	**Yes**		**No**

If no, please confirm why you have not sought consent or are overriding consent (please tick):

Public interest (risks to others)		**Risk of serious harm**		**Suspected serious crime**	
Adult at risk lacks mental capacity to provide consent (best interest decision made)		**Ability to consent is affected by threatening or coercive behaviour**		**Seeking consent would increase risks to the adult or others**	

Other, please provide details below:

Do you think the adult at risk has mental capacity in relation to making decisions about their safety?	**Yes**		**No**	
If no, has a mental capacity assessment been undertaken?	**Yes**		**No**	
Do you think the adult at risk would have substantial difficulty in participating in the safeguarding adults process?	**Yes**		**No**	

If yes, is there a suitable person who could represent them? (e.g. family member, friend, advocate)	**Yes**		**No**		**Unknown**	

Please provide the name and contact details of this suitable person:

Has the adult at risk's family been informed of the concerns (where the adult has consented to this)?	**Yes**		**No**	

If you think the adult at risk may need support to participate in the safeguarding adults process, please provide details of what support may be required:

What does the adult at risk (or their representative) say that they want to happen as a result of the safeguarding adults enquiry (desired outcomes)?

Signed:		**Date:**	
Printed:		**Time:**	

What happens next?

The local authority will use the information in this form to make an assessment of the level of harm and vulnerability of the adult at risk. Further information may be needed from you and other organisations involved. This assessment, alongside the desired outcomes of the adult at risk (or their representative) will determine whether the Safeguarding Adults Enquiry continues. The initial decision to progress, or not, is made by a manager in the local authority. Feedback will be provided to the person who completed this form, unless specified otherwise. **It is your responsibility to challenge decisions that you disagree with.** Please contact the local authority manager with your concerns. If you remain unhappy with the decision that has been made, please escalate your concerns to the Safeguarding Adults Unit, 0191 278 8156.

This document contains personal and sensitive information when completed and should be stored securely according to your own organisation's procedures. It is your responsibility to ensure that this is done.

Information about how this document should be sent safely and securely

Once completed, this document contains personal and sensitive information.

Sending the information to Adult Social Care

- The form should either be sent to Community Health and Social Care Direct or to the adult at risk's allocated Social Worker if you are aware that they have one. If you do not know, please send the form to Community Health and Social Care Direct. It is the responsibility of the person sending the form to ensure it has arrived with Adult Social Care.
- It is best practice to telephone prior to sending the form, this is particularly important if you are faxing the form (see below).

  Community Health and Social Care Direct: 0191 278 8377 (Mon-Fri, 8am-5pm)
- The form should be sent on the next working day following the concern. It is not necessary to contact or to send the form to the Out of Hours Service. However, the Out of Hours Service can provide help with urgent social care if that is required (0191 278 7878).
- It is intended that you complete the form electronically and then either send it via email or print a copy and fax or post it. If you handwrite the form, please make sure that your handwriting is legible. Prior to printing a copy off you may wish to increase the box sizes or add further sheets if you are completing it by hand.

Options for sending the Safeguarding Adults Initial Enquiry Form

- **Email.** The completed form should only be sent by email if secure email addresses are used by both sender and receiver (**.pnn.police.uk, .cjsm.gov.uk, .gsi.gov.uk, .nhs.net, .gcsx.gov.uk)** or the email is encrypted (contact your IT support about email encryption). The subject field of the email address should clearly be marked OFFICIAL. Internal email systems are not usually secure. **Where there are no secure email addresses or encryption, this document should not be sent electronically.**

  Community Health and Social Care Direct secure email: sda@newcastle.gcsx.gov.uk
- **Fax.** The procedure for sending information securely by fax is as follows:
  1. The sender needs to check the fax number they are sending the form to.
  2. Ensure the recipient is waiting at the fax machine for the fax.
  3. Fax covering note should be used and needs to be marked "OFFICIAL".
  4. Send the fax

5. The recipient then needs to confirm receipt with the sender.

Community Health and Social Care Direct Fax: 0191 278 8312

- **Post.** The documents should be sent via recorded delivery in external post. Documents should be double enveloped. On the outer envelope it should clearly state “To be opened by named addressee only”. There should be a return address on the outer envelope. The inner envelope should be marked “OFFICIAL”. **Do not use internal post**.

Community Health and Social Care Direct Address:

2nd Floor, Allendale Road, Newcastle upon Tyne, NE6 2SZ

- **Delivery in person.** The form can be hand delivered. You should obtain a signature from the intended recipient to confirm delivery.

You can contact Community Health and Social Care Direct (0191 278 8377) if you need help or advice in relation to completing or sending this form.