Safeguarding Children and Vulnerable Adults

A guide for prosthetists and orthotists

Contents

Contents (continued)

This document contains important safeguarding information and includes descriptors of childhood abuse, if you have experienced childhood abuse, further support can be found at NAPAC - Supporting Recovery From Childhood Abuse.

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Safeguarding is everybody's business.

Safeguarding is part of your duty of care.

You have a legal obligation to ensure the safety and wellbeing of service users, staff and visitors.

You are accountable for what you do or choose not to do.

Produced for Prosthetists and Orthotists, this guidance is an essential reference point and does not replace the requirement of statutory and mandatory training within the NHS, contracted, and private healthcare service providers.

Executive summary

This guidance document by the British Association of Prosthetists and Orthotists (BAPO) outlines the essential policies, principles, and procedures related to safeguarding children and vulnerable adults. It serves as a comprehensive reference for prosthetists and orthotists working across NHS, private, and voluntary healthcare sectors.

The document emphasises that safeguarding is a shared responsibility embedded in the duty of care of all healthcare professionals. It underscores legal obligations and ethical duties to protect service users from abuse, harm, and neglect.

Key areas covered include:

- **Definitions and Categories of Abuse:** Physical, emotional, sexual, financial, neglect, self-neglect, domestic abuse, and modern slavery, among others.
- **Safeguarding Procedures:** Guidance on identifying, reporting, and responding to abuse, including handling disclosures and dealing with allegations against staff.
- **Special Topics:** Includes safeguarding protocols for children (e.g., Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE), and Looked After Children (LAC)), individuals with mental capacity issues, dementia, and learning disabilities.
- **Legal Frameworks:** Detailed application of the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS), and other legislation relevant to consent, capacity, and care decision-making.
- **Best Practice Principles:** Highlights empowerment, prevention, proportionality, protection, partnership, and accountability.
- **Operational Tools:** Includes sample forms, flowcharts, and statements to aid in assessments and documentation.

Ultimately, the document seeks to standardise safeguarding practices and encourage proactive, informed, and compassionate responses to concerns, ensuring service user dignity, safety, and rights are consistently upheld.

Dr Nicky Eddison
Chair, BAPO

Introduction

Safeguarding means protecting people's health, wellbeing, and human rights and enabling them to live free from harm, abuse, and neglect.

The safety and welfare of children and vulnerable adults has become an issue of increasing public concern. These guidelines should be consistent with the more comprehensive procedures which operate in NHS Trusts/Health Boards within which prosthetists and orthotists are required to abide by. Prosthetists and orthotists working in the private and voluntary sector where child or vulnerable adult safeguarding policies may not exist, should be aware of and abide by the information outlined in this document.

All prosthetists and orthotists have a responsibility for safeguarding children, young people, and adults at risk in the course of their daily duties and for ensuring that they are aware of the specific duties relating to their role. Safeguarding is an integral part of healthcare and therefore it is everybody's business to safeguard the rights of service users.

All clinicians and staff coming into contact with children or vulnerable adults should be aware of these policies considering that child and vulnerable adult safeguarding is an overall awareness of a child's or vulnerable adult's welfare across all aspects of the practice.

All staff and volunteers must recognise their duty and feel able to raise concerns about poor and unsafe practices concerning children/vulnerable adults and that those concerns are addressed sensitively and effectively in a timely manner. If you are a private clinician, we recommend having a Safeguarding Statement within your practice for staff to follow (see Appendix 1). Local Authority contact numbers should be sought and used in conjunction with this document. These contact details will be found via your Local Authority's website.

As per The Care Act Statutory Guidance, a young person is anyone under the age of 18 years (16 years in Scotland) and a vulnerable adult is any person aged 18 years or over (16 years in Scotland), who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- 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.

This may be because they have a mental health problem, a disability, visual, or hearing problems, are old or frail, or have some form of illness.

BAPO recommends reading this guide in conjunction with BAPO's publication 'A comprehensive guide to clinical record keeping, data protection, confidentiality, and consent'.

BAPO recommends that prosthetists and orthotists should:

- Be **professionally curious** about what you see, hear, or feel.
- Consider who **to escalate** your concern to for further advice and support where needed.
- Consider the **barriers people may face** when they are experiencing abuse and neglect— trust issues, fear of reprisal, shame, guilt, carer fatigue, or stress.
- Not take things **at face value** – question what is stated, escalate, and ask for more information.
- Not let your attitudes, assumptions, and cultural norms cloud your judgements and concerns.
- Be aware of **unconscious bias**, which are automatic judgments, assumptions, and stereotypes that influence our decisions and actions without our conscious awareness. Awareness can help to increase the effectiveness of safeguarding, and fairness of safeguarding practices.
- Not wait for a **crisis** to emerge, be proactive and work together to prevent abuse or neglect from occurring or getting worse.

Observe the principles of safeguarding

- **Empowerment:** People being supported and encouraged to make their own decisions and informed consent.
- **Prevention**: It is better to take action before harm occurs.
- **Proportionality:** The least intrusive response appropriate to the risk presented.
- **Protection:** Support and representation for those in greatest need.
- **Partnership:** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting, and reporting neglect and abuse.
- **Accountability:** Accountability and transparency in safeguarding practice.

Abuse

Safeguarding duties apply to all people who:

- Have care and support needs.
- Are experiencing or at risk of abuse or neglect, and
- As a result of those care and support needs, are unable to protect themselves from either the risk of, or experience of, abuse or neglect.

Abuse is mistreatment by any other person or persons that violates a person's human and civil rights. The abuse can vary from treating someone with disrespect in a way that significantly affects the person's quality of life, to causing actual physical or emotional suffering.

Safeguarding and abuse

Abuse and neglect come in many different forms as detailed in the Care Act 2014.

1. Physical abuse (assault, misuse of medicine or restraint, inappropriate physical sanctions, hitting, pushing, slapping).
2. Domestic abuse (physical, sexual, financial, emotional 'honour' based violence, coercive or threatening behaviour and female genital mutilation (FGM)).
3. Sexual abuse including Sexual Exploitation (including unwanted, inappropriate touching, kissing, or sexual intercourse, or sexual contact to which a person cannot consent).
4. Psychological abuse (humiliation, unreasonable/unjustified withdrawal of service or support network, Shouting, screaming or swearing, threats, intimidation, use of fear).
5. Financial or material abuse (theft, fraud, scams, pressure to sign over money or property or undertake a financial transaction, lack of control/access to money, misuse of Lasting Power of Attorney / Power of Attorney).
6. Modern slavery (slavery, human trafficking, forced labour, domestic servitude, inhuman treatment).
7. Discrimination - which includes discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, or sexual orientation (known as protected characteristics under the Equality Act 2010).
8. Organisational abuse (neglect/poor care practice).
9. Neglect and acts of omission (ignoring medical, emotional or physical care needs, withholding of necessities of life such as medication, nutrition).
10. Self-neglect (lack of self-care to an extent that it threatens personal health and safety, hoarding, and declining support from health or social care).

Abuse can occur anywhere, for example at home, care home, hospital, college, or in public places.

Who can be an abuser?

It is important to remember that anyone can be an abuser, including:

- A family member
- A friend
- Other service users/adults at risk
- Young people
- A professional worker/ colleague
- Carers
- Volunteers
- Strangers

When children or vulnerable adults are suffering from physical, sexual, or emotional abuse, or may be experiencing neglect, this may be demonstrated through the things they say (direct or indirect disclosure), through changes in their appearance and their behaviour.

Physical abuse

The first step should be to enquire about any injuries that have aroused your concern, by speaking with the young person/vulnerable adult. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child/vulnerable adult. Physical harm may also be caused when a parent or carer feigns the symptoms or deliberately causes ill-health to a dependent. This situation is commonly described using terms such as fabricated and induced illness or Factitious Disorder Imposed on Another (FDIA). Self-harm also comes under the category of physical abuse. If you are satisfied with the information, a note should be made of the incident in your clinical notes, and the General Practitioner (GP) informed in writing. This is so that the GP will be alerted if there is a pattern of repeated incidents or injuries.

Domestic Abuse

Domestic abuse as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer. This can occur in several forms, including:

- **Constant Criticism:** Somone being repeatedly criticised for their appearance, personality, or choices, making them feel inadequate.
- **Belittling Remarks:** Someone being told they are stupid, worthless, or not good enough, undermining their self-esteem.
- **Manipulation:** Being made to feel guilty, blamed for things the individual did not do, or having emotions twisted to exert control.
- **Control:** Having freedom restricted, being told who an individual can and cannot talk to or being monitored.
- **Isolation:** Being deliberately kept away from friends and family, making it difficult to have support.
- **Threats:** Being threatened with physical harm, abandonment, or with the destruction of property.
- **Gaslighting:** Somone being made to question their own sanity, memory, or reality, making someone doubt their own perceptions.

In addition to assessing the impact of domestic abuse on the adult victim please remember to consider the impact of this abuse on any child in the household.

In cases of suspected domestic abuse, it is best practice to perform the following:

- Always talk to the individual alone.
- Never pressure an individual to leave their partner.
- Discuss and ensure a safety plan is in place.
- Reinforce options.
- Explain the role of expert agencies.
- Always use a professional interpreter.
- Document all contacts and concerns.
- Discuss complex cases at supervision.

Emotional abuse

Emotional Abuse is the persistent emotional ill-treatment of a child/vulnerable adult such as to cause severe and persistent adverse effects on the child's emotional development or the vulnerable adult's emotional health. It may involve conveying to children/vulnerable adult that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may feature age and developmentally inappropriate expectations being imposed on children. It may involve causing the individual frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child/vulnerable adult, though it may occur alone.

Neglect

Neglect is the persistent failure to meet a child's/vulnerable adult's basic physical and/or psychological needs, likely to result in the serious impairment of the person's health or development. It may involve a parent or carer failing to provide adequate food, shelter, and clothing, failure to protect the individual from physical harm or danger or the failure to ensure access to appropriate medical care or treatment. It may also include neglect, or unresponsiveness to, a child's basic emotional needs. If you suspect emotional abuse or neglect you should record the reasons for your concern in your service user records.

Sexual abuse

Sexual abuse usually comes to light in a different way to physical abuse or neglect. Often there may be a change in a child's/vulnerable adult's behaviour or personality. The most usual way, however, is for the person to confide in someone, typically a healthcare professional, teacher, or volunteer. If this happens to you, you should listen to the person and explain that you will report the issue to ensure they are supported and protected. It is important that you do not discuss the incident with the young person or vulnerable adult so as not to 'contaminate evidence'.

Financial abuse

This is mainly related to vulnerable adults and is a type of exploitation. It usually involves a relative, carer, visitor, or friend committing theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or misusing property, possessions, and benefits.

If you suspect any of these types of abuse have occurred, you must report it to the appropriate authorities including their GP and the local safeguarding team.

Your NHS Trust/Health Board should have a safeguarding lead/public protection lead and clear safeguarding policies and procedures. If you do not work for an NHS organisation, you can find your local safeguarding team via a quick internet search. There may be separate teams for adults and children.

What to do if you are worried that a young person or vulnerable adult is being abused?

What is important is that appropriate action is taken whenever it is suspected that anyone is being abused. What action you take will be dependent on the type of abuse, and the following is offered as a guide:

- Discuss with your line manager immediately.
- If you are unclear if it is a concern of abuse, contact your organisation's safeguarding team or your local safeguarding team to discuss.
- If appropriate make a referral.

Dealing with a disclosure

Dealing with a disclosure from a child or vulnerable adult, and a safeguarding case in general, is likely to be a stressful experience. The prosthetist/orthotist should, therefore, consider seeking support for themselves and discuss this with the designated members of staff. If a child or vulnerable adult discloses that they have been abused in some way, the prosthetist/orthotist should:

- Listen to what is being said without displaying shock or disbelief.
- Accept what is being said.
- Allow the person to talk freely.
- Avoid asking leading questions.
- Reassure the person but not make promises which might not be possible to keep.
- Not promise confidentiality.
- Reassure the person that what has happened is not their fault.
- Listen rather than ask questions.
- Stress that it was the right thing to tell.
- Not criticise the alleged perpetrator.
- Explain what has to be done next and who has to be told.
- Make a written record.
- Non-action is not an option in child and vulnerable adult protection. **You must act immediately: do not assume someone else will.**
- Liaise with Social Services.

Reporting suspected safeguarding issues

If you suspect a child or vulnerable adult is being abused or is at risk in some way it is best to try and ascertain the facts with them (or their guardians if you feel this will not put them in anymore danger). If you have concerns, report them to the person's GP or social worker. Local authorities have dedicated social workers who handle cases of abuse. Follow your organisation's policies, but if none are in place, contact your local council and ask for the Adult Protection or Safeguarding Coordinator—or search online for relevant contacts in your area. You can also speak to the police, as some forms of abuse are criminal offences that require their intervention." You can also contact Hourglass and for children you can contact the NSPCC. If the person is in danger or needs medical attention, call the emergency services.

If you are concerned about the safety or well-being of someone living in a care home, you can contact the Care Quality Commission (CQC) in England. In Wales you can contact the Care Inspectorate Wales. In Northern Ireland you can get further information from NIdirect. In Scotland you can contact The Care Inspectorate.

For specific information on what to do to report child abuse and your legal requirements please visit: www.nspcc.org.uk/what-you-can-do/report-abuse/what-if-suspect-abuse/

Safeguarding children

All those who come into contact with children and families in their everyday work, including staff who do not have a specific role in relation to child protection, have a duty to safeguard and promote the welfare of children. The best interest of the child must always remain the priority.

> *"See it through the child's eyes"*
>
> Laming (2009)

Child abuse and neglect' is a generic term encompassing all ill treatment of children including serious physical and sexual assaults as well as incidences where the standard of care does not adequately support the child's health or development. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm.

Working Together to Safeguard Children (2023) sets out definitions and examples of the four broad categories of abuse: Neglect, Physical abuse, Sexual abuse, and Emotional abuse. The categories overlap and an abused child frequently suffers more than one type of abuse.

You may come across the following terms in relation to the safeguarding of children:

- **Child in Need:** Children who are 'unlikely to reach or maintain a satisfactory level of health or development or their health and development will be significantly impaired, without the provision of services' (Section 17 Children Act, 1989).
- **Child in Need of Protection:** Children who have suffered or are at risk of significant harm (Section 47 Children Act, 1989).

Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning, scalding, drowning, suffocating, or otherwise causing physical harm to a child or young person. Physical harm may also be caused when a parent or carer fabricates the symptoms of or deliberately induces illness in a child.

Key areas to consider:

- Is there an explanation for the injury?
- Is the explanation compatible with the injury and the developmental stage of the child?
- Has there been a delay in seeking help?
- The child's age and developmental ability.
- Bruising in soft parts or multiple bruising.
- Bite marks (human/animal).
- Burns, including cigarette burns.
- Fractures (depending on type, history).
- Injuries in children who are not independently mobile e.g. babies and Disabled children with physical immobility.
- Number of 'accidental' injuries may indicate a lack of parental supervision.

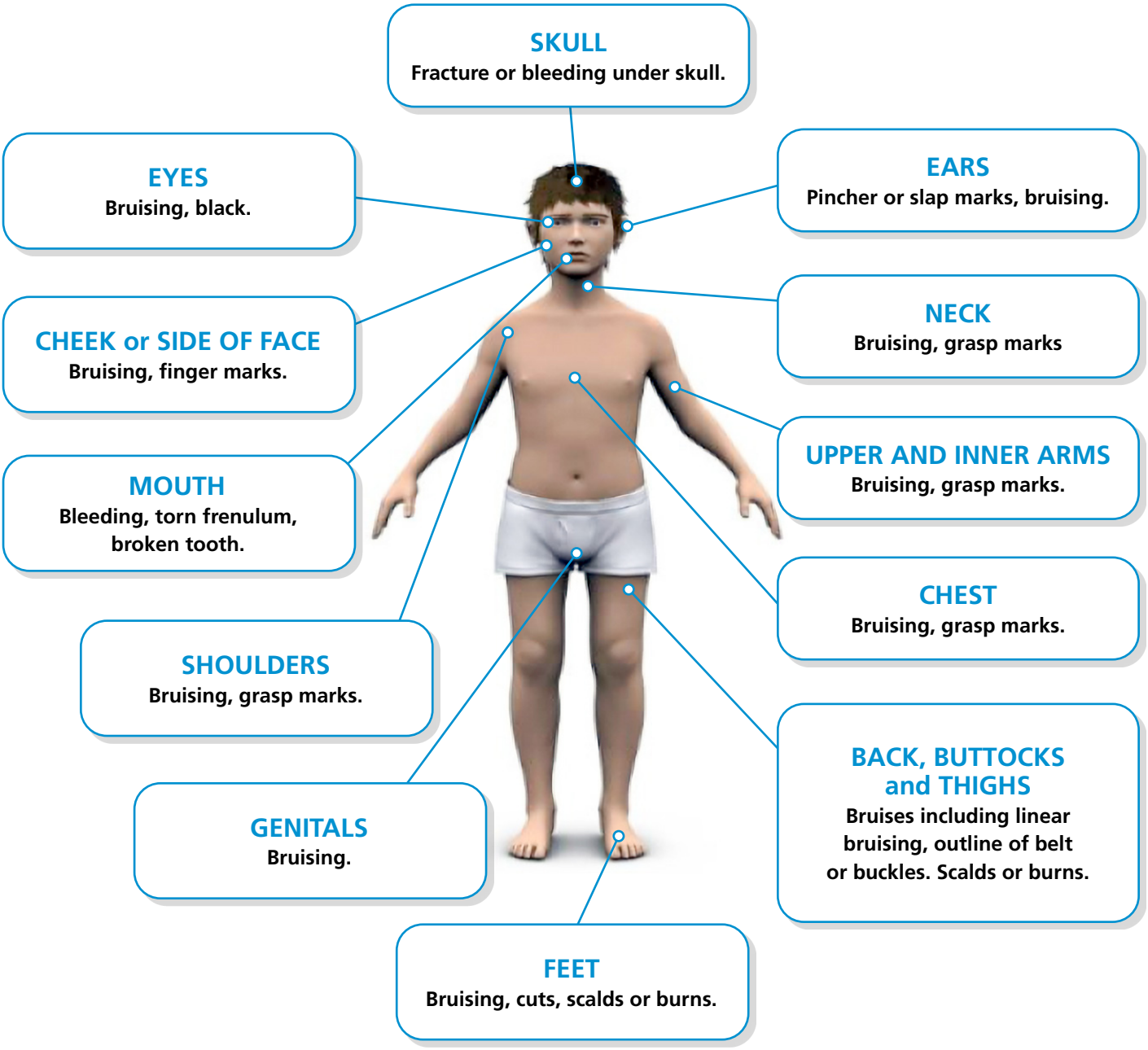


Figure 1: Injuries that may indicate physical abuse

Factitious disorder imposed on another (FDIA)

This is a condition where a child suffers harm through the deliberate action of her/his main carer by:

- Fabrication of signs and symptoms including fabrication of past medical history, hospital charts, records, letters and documents, and specimens of bodily fluid.
- Induction of illness by a variety of means.
- Unnecessary or invasive medical treatment.

When to suspect FDIA:

- Reported signs and symptoms are not explained by any existing or new medical condition. New symptoms are reported on resolution of previous ones.
- Physical assessment and results of investigations do not explain reported signs and symptoms.
- A poor response to prescribed medication or treatment.
- Reported symptoms are not observed in the absence of the carer.
- Over time the child is repeatedly presented with a range of signs and symptoms.
- The child's normal daily activities are curtailed beyond what would be expected for any medical condition the child is known to suffer.

What to do if FDIA is suspected:

- **DO NOT** discuss your concerns with parent/carer until guidance sought from the safeguarding lead in your Trust/ Health Board or organisation.
- Closely observe child and family interactions.
- Provide clear documentation in clinical notes.
- Seek medical evaluation by a Consultant Paediatrician.
- All tests and results should be fully and accurately recorded including those with negative results.
- Compile a full chronology of all health contacts and events (including reported symptoms, timelines, and actions to date).
- Collate information from other healthcare professionals such as GP / Health Visitor / referring party.
- Request an MDT meeting to review information and determine action to undertake i.e. social care +/- police referral.

Abuse and Neglect

Emotional abuse

Emotional abuse is the persistent maltreatment of a child such as to cause severe adverse effects on the child's emotional development. This includes:

- Seeing or hearing the ill-treatment of others, e.g. domestic abuse.
- Conveying to children that they are worthless or unloved.
- Not giving children an opportunity to express their views.
- Inappropriate expectations being imposed on children for their age/development.
- Bullying.

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. This may or may not be deliberate. This can be cumulative over a period of time.

Be alert to the possibility of neglect in children who present with:

- Weight loss/failure to thrive/obesity.
- Poor dental hygiene/dental cavities.
- Poor physical appearance: dirty/unkempt/inappropriate clothing.
- Not attending medical appointments.
- Non-compliance with medication.
- Not attending school.
- Children left home alone/inadequate supervision.

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities. This includes non-contact activities such as involving children looking at, or in the production of sexual images, or grooming a child in preparation for abuse (including via the internet).

When to suspect child sexual abuse:

- If a child/young person makes an allegation.
- If a child presents with any relevant injuries or medical symptoms (i.e. ano-genital injury, unexplained vaginal/rectal bleeding, soiling/incontinence/Sexually transmitted infections/pregnancy).
- If an adult observes any sexualised, troubled, or disturbed behaviours in a child.
- If a child is having contact with an adult who poses a risk to children.

If sexual assault has taken place, the forensic window period is as follows:

- Males and females under 13 years - up to 3 days.
- Females over 13 years - up to 7 days.
- Males over 13 years - up to 3 days.

NB: Disabled children may be more vulnerable to all forms of abuse because they may:

- Have less outside contact with other people than non-disabled children.
- Have reduced capacity to resist or avoid abuse.
- Have communication difficulties which may make telling others very difficult.
- Be inhibited about complaining.

Barriers to professionals acting on safe guarding concerns

A lack of professional confidence or knowledge regarding safeguarding, a lack of skills, experience, or understanding of a child's disability can take the focus away from the child's experience and views. This can mean that safeguarding concerns are not recognised and appropriate action is not taken.

Issues which can impact the effectiveness of professional practice include:

- completing assessments that focus on needs relating to disability rather than looking at a child's wellbeing more holistically
- not understanding or acknowledging the cultural aspects and complexities of being d/Deaf or having a disability
- feeling overwhelmed or fearful or a child's disability
- relying on parents or carers to speak for their children, rather than communicating directly with children
- believing that d/Deaf children and children who have disabilities don't experience abuse
- assuming that a d/Deaf child or a child who has a disability will be an unreliable witness.

For more information please see:
https://learning.nspcc.org.uk/safeguarding-child-protection/deaf-and-disabled-children#skip-to-content

Female genital mutilations (FGM)

Female genital mutilation (FGM), sometimes called female circumcision or female genital cutting, comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The practice of FGM is internationally recognised as a violation of the human rights of girls and women. It reflects deep-rooted inequality between sexes and constitutes an extreme form of discrimination against girls and women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's right to health, security, and physical integrity; the right to be free from torture and cruel, inhuman, or degrading treatment; and the right to life, in instances when the procedure results in death.

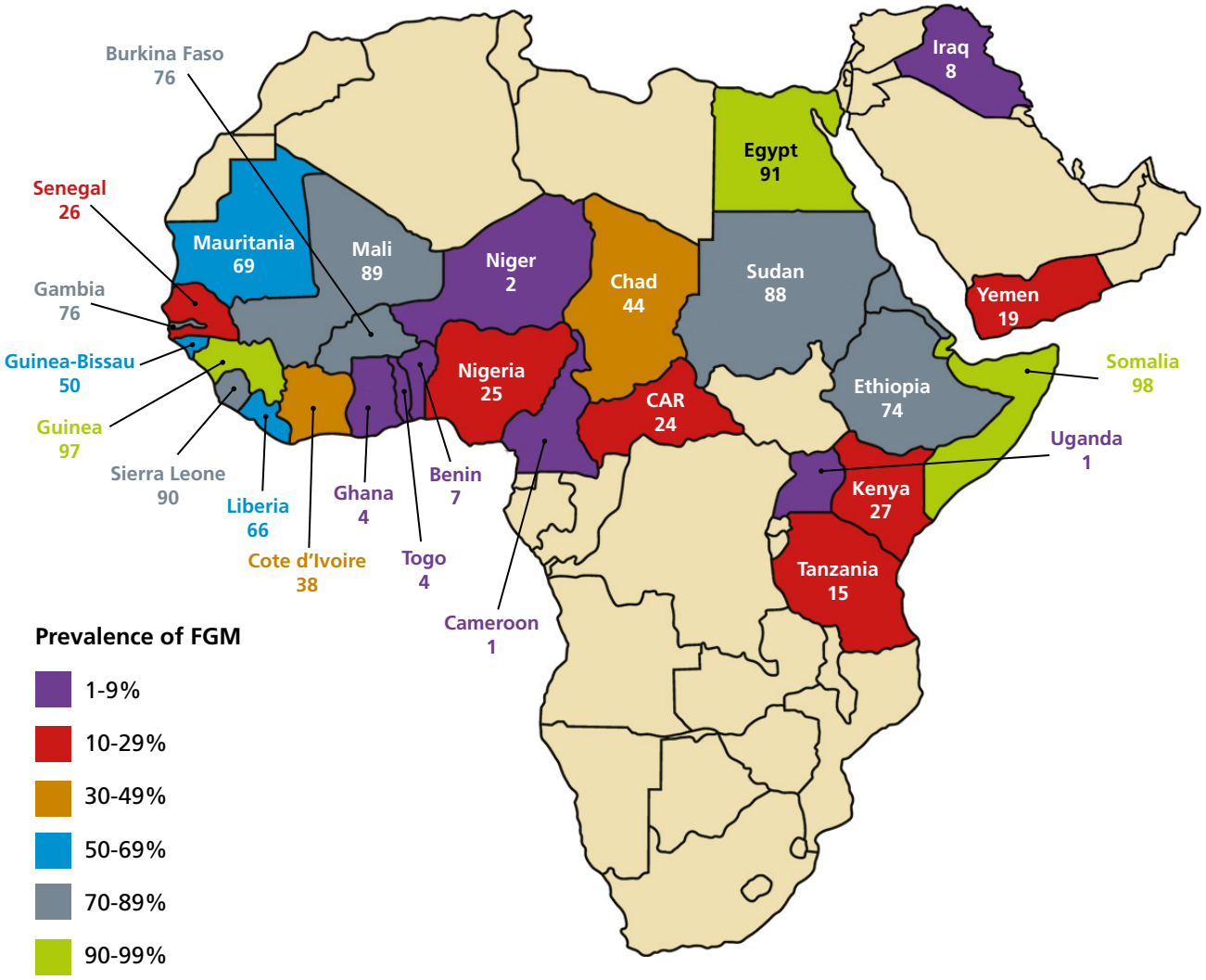


Figure 2: Prevalence of FGM. UNICEF 2015

FGM is a criminal offence in the UK, and this includes taking a child abroad for the purpose of undergoing FGM.

The practice has no health benefits for girls and women and can result in severe bleeding and problems urinating, and later cysts, menstrual difficulties, infections, as well as complications in childbirth and increased risk of newborn deaths. Other health impacts include:

- Psychological trauma.
- Renal impairment.
- Chronic vaginal and pelvic infections.
- Complications affecting sexual intercourse.
- Fertility problems.
- Death.

Identifying risk:

- Does the individual have a parent from a practicing community?
- Have any other family members had FGM?
- How integrated are the family into western society?
- Has the individual talked about FGM to other children?
- Has the individual been removed from Personal, Social, Health, and Economic (PSHE) education?
- Has the individual referred to a 'special procedure'?
- Has the individual been taken out of the country for a prolonged period?
- Is the family planning a trip to a country of high prevalence?

Action to take:

- Give the individual time to talk and be willing to listen.
- Use simple language and ask straightforward questions; use terminology that the individual will understand.
- If English is not the girl's or woman's first language use a professional interpreter, not a family member.
- Ensure that a female professional is available to speak to the girl or woman if required.
- Be sensitive to the fact that the individual may be loyal to their parents.
- Be non-judgemental; explain the illegality and health risks of FGM but not blame the girl or woman.
- Get accurate information about the urgency of the situation if the individual is at risk of FGM.
- Seek urgent advice from the safeguarding children/FGM leads.

BUT do not assume that all women who have experienced FGM or all men from affected communities will support the practice.

All healthcare professionals are required to report to the police, when in the course of their duties, a female under 18 years old:

- Tells you she has had FGM.
- Has signs which appear to show she has had FGM.

It does **not** apply in relation to at risk or suspected cases or if the woman is over 18 years old.

What to do

You must phone the police using the non-emergency crime number **101** as soon as possible. This **must** be done by the healthcare professional who identifies FGM/receives the disclosure. If you do not comply, the Health and Care Professions Council (HCPC) may consider the circumstances under existing 'Fitness to Practise' proceedings. When you call 101 explain that you are making a report under the FGM mandatory reporting duty and provide:

- **Your details:** name, contact details, role, place of work.
- **Details of your organisation's designated safeguarding lead:** name, contact details.
- **The child's details:** name, age/date of birth, address.
- Confirm that you have undertaken or will undertake safeguarding actions.
- Request a police reference number from the police and record this in the child or young person's healthcare record.
- Discuss with the child/family that you are making this notification under the duty.
- **If you think a girl has been recently cut or is at imminent risk, act immediately. Call 999 if deemed that there is an immediate risk.**

Remember: Mandatory reporting is only one part of safeguarding against FGM. Contact the local Safeguarding Children Team and follow the local Trust's / Health Board's Safeguarding Children and FGM Procedures.

Child sexual exploitation (CSE)

Often children and young people who are victims of sexual exploitation do not recognise that they are being abused. There are a number of warning signs that can indicate a child is being groomed for sexual exploitation and behaviours that can indicate that a child is being sexually exploited. To assist you in remembering and assessing these signs and behaviours the '**SAFEGUARD**' mnemonic is useful. *(Pan-London Child Sexual Exploitation Operating Protocol (Metropolitan Police, 2015))*

Sexual health and behaviour:
Evidence of sexually transmitted infections, pregnancy, and termination; inappropriate sexualised behaviour.

Absent from school or repeatedly running away:
Evidence of truancy or periods of being missing from home or care.

Familial abuse and/or problems at home:
Familial sexual abuse, physical abuse, emotional abuse, neglect, as well as risk of forced marriage or honour-based violence; domestic violence; substance misuse; parental mental health concerns; parental criminality; experience of homelessness; living in a care home or temporary accommodation.

Emotional and physical condition:
Thoughts of, or attempted, suicide or self-harming; low self-esteem or self-confidence; problems relating to sexual orientation; learning difficulties or poor mental health; unexplained injuries or changes in physical appearance.

Gangs, older age groups, and involvement in crime Involvement in crime:
Direct involvement with gang members or living in a gang-afflicted community; involvement with older individuals or lacking friends from the same age group; contact with other individuals who are sexually exploited.

Use of technology and sexual bullying:
Evidence of 'sexting', sexualised communication on-line or problematic use of the internet and social networking sites.

Alcohol and drug misuse:
Problematic substance use.

Receipt of unexplained gifts or money:
Unexplained finances, including phone credit, clothes and money.

Distrust of authority figures:
Resistance to communicating with parents, carers, teachers, social services, health, police, and others.

These factors are also indicative of trafficking and other forms of exploitation such as County Lines.

Child and adolescent mental health

Mental health issues in children include depression, anxiety, and conduct disorders, and are often a direct response to what is happening in their lives. They may manifest in a deliberate overdose or self-harm. Teenagers often experience emotional turmoil as they grow up. Some young people find it hard to make the transition into adulthood and may experiment with alcohol, drugs, or other substances that can affect their mental health.

There are certain risk factors which make some children more likely to experience problems than others, although these do not necessarily mean that difficulties will arise. Some of these risk factors include:

- Having a long-term physical illness.
- Having a parent who has mental health problems.
- Problems with substance abuse.
- Experiencing loss such as parents' divorce or a bereavement.
- Severe bullying/ physical / sexual abuse/neglect.
- Long standing educational difficulties.
- Taking on adult responsibilities.

What to do

- Liaise with the local Child and Adolescent Mental Health Services (CAMHS) and public protection team who will undertake a risk assessment to determine need and safety plan. Based on the assessment refer to Social Care if the threshold is met.
- Consider appropriate location for where the child is cared for.
- Assess safety of the environment and remove items that could cause harm i.e. sharp objects/medications.
- Refer to the local Restrictive and Therapeutic Holding Policy to determine level of observation and/or if use of a Registered Mental Health Nurse (RMN) is required.
- Complete behaviour care plan and daily activity plan for the child or young person.
- Consider drug screening if indicated.

Additional considerations for in-patients

- Is the child at risk of absconding? Record description of child. Inform security and Psychiatric Nurse Clinicians (PNPs).
- There must be a multidisciplinary team meeting discussion prior to discharge. The child must be both medically and psychiatrically cleared prior to discharge.
- Discuss and document home safety and contingency plan with the family.

Looked after children (LAC)

A 'LAC' refers to a child up to 18 years of age who is legally accommodated (for more than 24 hours) by the Local Authority. The main reason for children and young people being taken into care is as a result of abuse or neglect. The term LAC includes unaccompanied asylum-seeking children, children in friends and family placements.

Looked After Children may be:

- Accommodated under voluntary agreement with their parents (Children Act 1989, section 20).
- Subject to a full care order (Children Act 1989, section 31) or interim care order (ICO) (Children Act 1989, section 38).
- Subject of emergency orders for their protection (EPO/PPO) (Children Act section 44 and section 46).
- Compulsorily accommodated (Children Act, section 21).

LAC does not include those children who have been permanently adopted, are privately fostered, or who are under a Special Guardianship Order (SGO).

LAC Facts

- LAC have the same health risks as their peers, but the extent is often exacerbated due to their previous experiences.
- LAC are at increased risk of mental health problems. They are more likely to experience mental and physical health issues such as speech and language problems, bedwetting, coordination difficulties, and sight problems.
- LAC are more vulnerable to Child Sexual Exploitation (CSE), being radicalised, joining gangs, and grooming due to previous experiences of abuse and neglect.
- A small proportion of children experience further abuse and neglect whilst in care.
- One third of all Care Leavers are not in education or employment by the age of 19 years - twice the number of 19-year-olds who have not been in care.
- A child is no longer classed as "Looked After" when they are either adopted, return home, or turn 18 years of age.
- LAC continue to be supported by the Local Authority as Care Leavers until they are 21 years old.

What to do if a LAC is seen in your service:

- Identify who has parental responsibility for consent (see section on page 21) and ensure their contact details are documented. The LAC will usually have a designated social worker who will liaise about consent to treat.
- If there is any ambiguity request evidence of the court order.
- Complete appropriate documentation e.g. healthcare records and alert.
- Establish who is allowed access to the child.
- As with all clinical notes, clearly document who attended the appointment with the child.
- Check up to date address and contact details are held.

Information sharing is key

- Inform the Safeguarding Children Team or discuss with your safeguarding supervisor.
- Inform Children's Social Care and the LAC Health Team of the attendance and copy them into any clinic letters/ reports. Check if letters can be sent to birth parents. Details of the foster carer's address should not be included in letters to the birth parents..
- Avoid sending clinic letters with birth parents' details to foster carers.

When a child or young person comes into care there is a statutory requirement that they have an Initial Health Assessment (IHA) undertaken to assess their health needs. If the child remains in care, then they will require a six monthly Review Health Assessment (RHA) if under the age of five years or an annual review for those over five years of age. The aim of the health assessment is to ensure that the children and young people in care achieve the best health outcomes.

Parental responsibility and consent

Parental responsibility (PR) is defined in law as:

> *"All the rights, duties, powers, responsibilities, and authority, which by law a parent has in relation to the child".*

Who has parental responsibility?

- A birth mother automatically has parental responsibility for her child from birth.
- A birth father usually has parental responsibility if he's either:
  - Married to the child's mother.
  - Listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in).
- A person having PR through a court order.
- Parents can share PR with the Local Authority (LA), or the LA can have PR via a court order.
- Foster carers do **not** have PR and cannot give consent for medical procedures or make decisions on the child's behalf, without the authorisation of a social worker. Adoptive parents have PR from the date the adoption order is granted.

Consent is decision and time specific. The child/young person or child's parent/person with PR must understand, be able to retain, believe, and use available information to reach a decision.

Young people 16 & 17 years old…

- Have presumed capacity to consent to treatment.
- Their refusal can be overruled by someone with PR or a court order but only in best interests (e.g. if risk of serious irreversible injury/death).

Child under 16 years of age…

- Have presumed lack of capacity to consent/refuse treatment.
- A person with PR can consent on child's behalf.
- A child who is deemed competent can consent to treatment.
- A competent child's consent cannot be overruled by those with PR but can by courts.
- A child's refusal can be overruled in their best interests by a person with PR or a court of law.
- PR refusal to consent may be overruled by a court order.
- Legal responsibility that a child has capacity lies with person taking consent.

Safeguarding assessment

Most children grow up in circumstances in which their needs are met. However, some children are not as fortunate and have some vulnerabilities due to factors such as parenting capacity, lifestyle, and social circumstances. It is important to carry out an assessment to establish what the needs of the child and family are, to determine the level of risk and to ensure appropriate support and interventions are in place. Remember that having vulnerabilities and risk factors does not necessarily mean a child is at risk of suffering harm.

Consider what needs to change to allow the child to be safe, healthy, enjoy and achieve, make a positive contribution and achieve economic wellbeing. Always seek the child's and parents' views.

Risk Factors

- **Child:** Preterm birth, low birth weight, physical/ cognitive/emotional disability, chronic, or serious illness, childhood trauma.
- **Caregivers:** Caregivers with learning disabilities, substance misuse, history of domestic abuse, including sexual violence or exploitation, and/or history of adverse childhood experiences (ACE's), history of violent offending or other criminal activity.
- **Family/Environmental:** Anti-social peer group, modern slavery/trafficking. Poverty, financial pressures, or poor housing — could be linked with a higher level of parental stress and an increased risk of child maltreatment. Maltreatment of other children within the family, or violence between family members.

Protective Factors

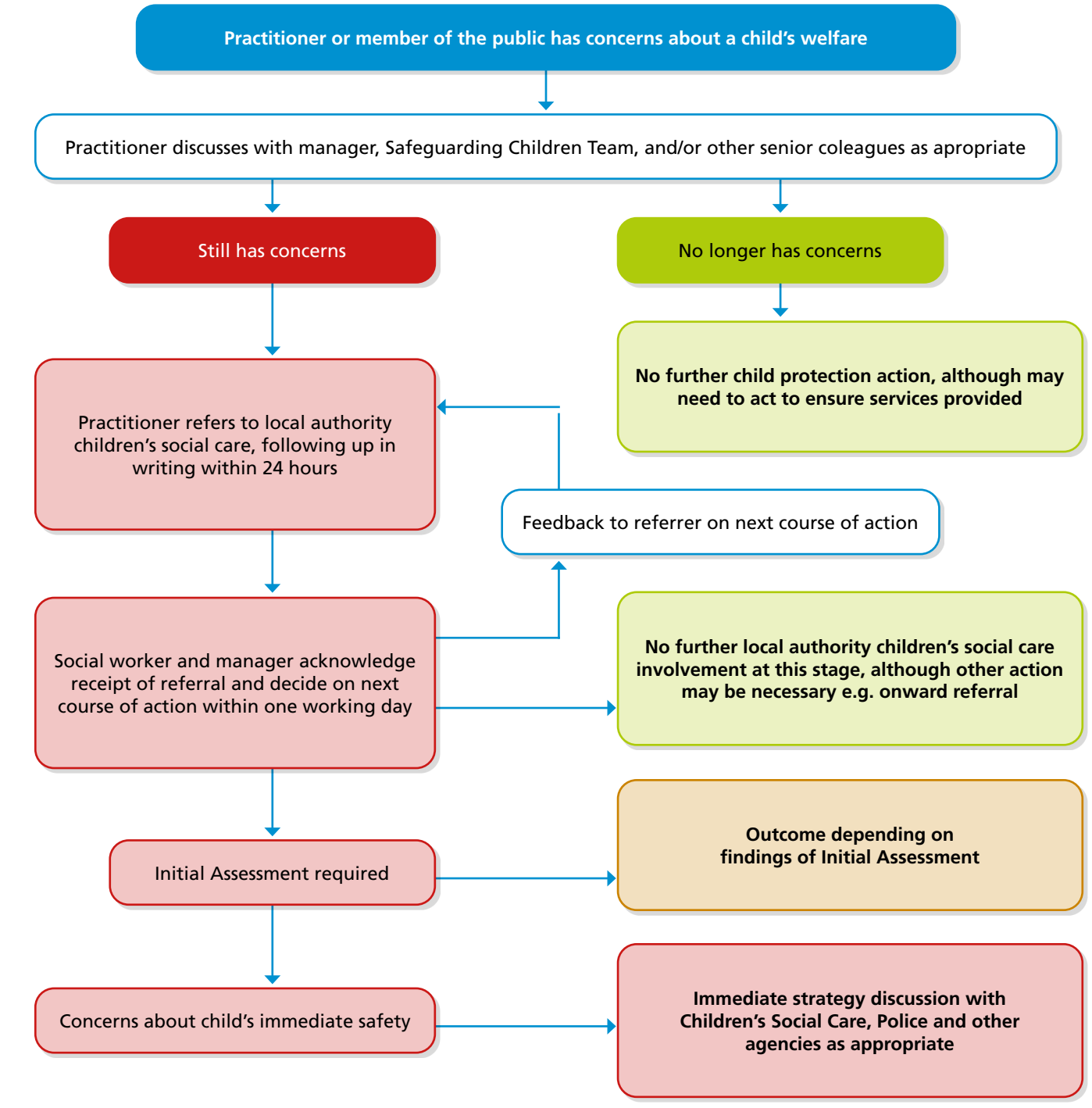
- **Child:** Good health; friendships; talents and interests; positive values; self-esteem; good social skills.
- **Caregiver:** Secure attachment; positive and warm care giver-child relationship; household rules/ structure; caregiver monitoring of child; extended family support structure.
- **Family/Environmental:** Caregiver employment, absence of poverty, engaging with health, social and education services; access to healthcare and schools; appropriate housing.

When conducting a safeguarding assessment, remember the following:

- **Respect:** Value all young people, remember how hard it can be for them to disclose abuse or exploitation.
- **Ask:** Be 'professionally curious' – ask questions and take young people's answers seriously.
- **Discover:** Be pro-active – stay alert and on the lookout for potential signs of abuse.
- **Approach:** Show warmth from the start – give young people a chance to build a relationship with you.
- **Respond:** Follow safeguarding procedures – keep the young person informed and involved.

Referral process

What to do if you're worried a child is being abused (2015):



What borough does the child live in? Check here: www.gov.uk/report-child-abuse-to-local-council

Figure 3: Knowing the signs of a child at risk. Adapted from www.wakefieldscp.org.uk/worried-about-a-child/

Mental Capacity Act

The Mental Capacity Act (MCA) 2005 provides a legal framework to support people who lack capacity to make decisions for themselves (**age 16 years and over**) wherever a health or social care decision is made.

All prosthetists and orthotists have a legal duty to have regard to the MCA 2005, which has five main principles:

1. **Presumption of capacity:** Individuals are presumed to have the capacity to make their own decisions unless proven otherwise.
2. **Support to make decisions:** Take practical steps to help someone make a decision on their own, before determining they lack capacity.
3. **Unwise decisions:** Just because an individual makes an unwise decision doesn't mean they should be treated as though they lack capacity.
4. **Best interests:** When a person lacks capacity, decisions and actions must be made in their best interests, considering their wishes, feelings, and values.
5. **Least restrictive option:** Any decision made must be the least restrictive option available to achieve the desired outcome which respects the person's rights and freedoms. Other, less restrictive options should be considered and applied whenever possible.

Service user consent should always be sought before any care and treatment decisions are made; however some service users may lack the capacity to consent to the care and treatment proposed.

For further details on mental capacity and consent see BAPO's Comprehensive guide to clinical record keeping, data protection, confidentiality, and consent.

Learning disabilities

A learning disability is defined by the Department of Health and Social Care (DHSC) (2001) as:

> *"…a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood."*

A learning disability is different for everyone. The degree of disability can vary greatly, being classified as mild, moderate, severe, or profound. In all cases, a learning disability is a lifelong condition and cannot be cured.

A learning disability is different to a learning difficulty, which is a reduced ability for a specific form of learning and includes conditions such as dyslexia (reading), dyspraxia (affecting physical co-ordination) and attention deficit hyperactivity disorder (ADHD). A person with a learning disability may also have one or more learning difficulties.

Additionally, there are several conditions and neurological disorders that often involve or cause some type of learning disability, including Down's syndrome, autism, meningitis, epilepsy, or cerebral palsy. A learning disability is caused by something which affects the development of the brain either before birth, during birth, or in early childhood.

Possible causes may include:
- an inherited condition – for example, Fragile X syndrome
- abnormal chromosomes – for example, Down's syndrome or Turner syndrome
- exposure to environmental toxins or infections and illness during pregnancy
- a very premature birth
- complications during birth, resulting in a lack of oxygen to the baby's brain
- illness – for example, meningitis or measles; or injury or trauma to the brain in early childhood.

Sometimes the cause of a learning disability remains unknown.

People with a learning disability may have:
- A reduced ability to cope independently (impairment of adaptive/ social functioning) which started before adulthood, with a lasting effect on development (Valuing People DH, 2009).
- An IQ of 70 or below.

Compared to people without a learning disability, people with a learning disability tend to experience:
- poorer physical health
- poorer mental health
- significant health inequalities.

The latest Learning from Lives and Deaths - People with a learning disability and autistic people (LeDeR) (2021) states the median age at death for people with a learning disability is 62 years. This is significantly less than the median age of death of 82.7 years for the general population.

LeDeR also reports that 49% of deaths were from an avoidable cause which could have been prevented by good quality healthcare, compared to 22% of deaths for the general population (as reported by the Office for National Statistics).

People with a learning disability are also:
- less likely to be working - in England, 5.1% of adults with a learning disability known to their local councils are in paid employment
- more likely to live in poverty (31% compared to 18%)
- more likely to experience chronic loneliness (50% compared to around 15 to 30%)
- more likely to be bullied and discriminated against.

NB: A learning disability is not a physical disability, and does not include:

- Dyslexia and other problems with reading writing or numeracy only.
- Emotional difficulties that may have impacted on learning.
- ADHD and hyperactive disorders.
- Autistic Spectrum Disorders (however these can also be present).
- Acquired brain injury/Head injury (unless in early childhood).
- Behavioural disorders.
- Deafness.
- Blindness.
- Forms of dementia.
- Other Neurological Conditions.

Possible indicators of a learning disability

- Difficulty following instructions.
- Difficulty understanding and processing information.
- Difficulty understanding abstract concepts such as time or directions.
- Repetition of phrases in conversation without expanding on the content.
- Acquiescence, going along with everything.

Reasonable adjustments

People with disabilities have the right to reasonable adjustments under the Equality Act 2010. This means hospitals and clinics must take steps to remove barriers and ensure equal access to healthcare for all. This includes things like providing information in easy read or plain English, allowing carers to stay with service users overnight, or ensuring accessible facilities. A reasonable adjustment is a change in the way services are delivered to people with a learning disability to ensure that the quality of services, the policies, and procedures that underpin practice work equally well for people with a learning disability. Examples of reasonable adjustments are:

- Offering first or last appointment or longer appointment times.
- Flexible visiting times for carers using the Carer Passport.
- Having a family member or carer present where possible.
- Providing accessible information such as communication book, easy read versions of information.
- Care that involves the person with a learning disability and their families/carers.
- Providing meaningful activities to engage with service users.

Supporting service users with a learning disability

1. **Prepare:** Find out the service user's needs in advance. Check who is involved.
2. **Find out the best way to communicate:** Ask the service user's family/carer. Not everyone uses speech, some people use signs, symbols or objects. Allow time for any processing delay.
3. **Make reasonable adjustments:** e.g. double appointment, minimise waiting, first or last appointment.
4. **Involve and listen to parents/carers:** They know the individual's needs. They can assist and identify distress or pain.
5. **Don't make assumptions about a person's quality of life:** They are likely to be enjoying a fulfilling life.
6. **Be clear on the law about capacity to consent:** Always use the Mental Capacity Act principles when helping the person to make decisions.
7. **Ask for Help:** Learning Disability Clinical Nurse Specialist and other specialist staff in the hospital and community.
8. **Ask if the person has a Health and Care Passport:** Which is designed to be a quick and easy way to give health and social care professionals more information about the individual to help in the provision of the right care and treatment. It should help health and care providers to understand what reasonable adjustments need to be made and how to communicate effectively so the voice of the person is always heard.

When communicating with people with learning disabilities, the following is useful to consider:

- Reduce background noise if possible.
- Allow plenty of time.
- Gain the person's full attention and maintain face to face contact.
- Use PLAIN LANGUAGE – avoid euphemisms.
- Keep sentences short.
- Talk in the first person.
- Use a communication box, if required.

As a general rule it's easier to understand an object than a photograph, and a photograph is often easier to understand than writing.

If you need to perform a task (e.g. take a cast);

- Show them the equipment you need to use and talk through the process.
- Demonstrate it on somebody else.
- Let them do as much as possible.
- Say when it's over and that it went well.
- Keep smiling!

Dementia and delirium care

Dementia

Dementia is a general term used to describe a set of symptoms. These symptoms often include:

- loss of memory.
- mood changes.
- problems with communicating.
- difficulty completing day-to-day tasks.
- problems with reasoning.

Dementia is progressive, which means the symptoms will gradually worsen. The speed at which this happens usually depends on the person and the type of dementia they have.

There are many different types of dementia, however they are often called by the same name as the condition that caused the dementia in the first place.

Always ensure a person living with a diagnosis of dementia is under the care of a local Dementia and Delirium team (DaD), who are available for advice and specialist input.

A person with dementia may present with the following challenges

- **Confusion:** a decline in short term memory, the person cannot remember. Prompting helps.
- **Agitation/Aggression:** fear, pain, needing the toilet, and delirium are common causes.
- **Wandering:** it is normal to walk, looking for familiarity, "Where am I?" "What am I doing here". Regular reminders and signs will help.
- **Non-compliance with care:** Does the person understand what you mean? Take time, keep calm, try again later.
- **Distress:** Use the 'This is Me' document to engage the person in activity, conversation, and familiar sights /sounds/ smells to distract and reduce anxiety.

As a rule of thumb, all adult emergency admissions over the age of 70 **must** be screened for dementia within 72 hours of admission.

Hospital Trusts/Health Boards should have dementia information packs available which are designed to provide information and support for carers of people with dementia. These packs usually include Dementia and delirium leaflets tailored for the local Trust/Health Board, Alzheimer's Society fact sheets, information on local and national support services and advice for carers on how to look after themselves.

For all in-service users with a diagnosis of dementia, the following are used:

- This is Me document.
- A **Forget me not** flower is above the bed, on the Service user Status at a Glance (PSAG) board and e-noting.
- A **blue wrist** band.
- **Pain Assessment Tool** (includes Abbey pain tool).
- **Dementia Care Plan and bundle.**
- **ABC chart** if displaying challenging behaviour.
- Dementia-friendly activity box.

Delirium

Delirium is an acute, temporary state of confusion that has been triggered by a physical factor. Delirium often has multiple causes, which can make it difficult to recognise and treat.

The Confusion Assessment Method (CAM) is a clinical tool used to screen for delirium, which assessed the following:

1. Acute onset and fluctuating course
2. Inattention (distractible)
3. Disorganised thinking
4. Altered consciousness

A result is considered CAM positive if a 'yes' is scored for questions 1, 2, and 3 and/or 4.

Some service users will benefit from having their carer provide them with support when in hospital. This support may include being present at investigations, out of hours visiting etc. In these cases, a Carer Passport can be produced, which is a document that can be given to carers who wish to provide extra support for their relative.

Chaperoning

A chaperone is present as a safeguard for both parties (service user and healthcare professionals) and is a witness to the conduct and the service user's continuing consent to the assessment or procedure.

Their presence adds a layer of protection for a clinician, particularly against allegations of improper behaviour. The use of chaperones: acknowledge a service user's vulnerability; provides emotional comfort and reassurance; assists in the assessment; assists with undressing service users and enables them to act as an interpreter.

The precise role of the chaperone varies depending on the circumstances. It may include providing a degree of emotional support and reassurance to service users but more commonly incorporates:

- Providing protection to healthcare professionals against unfounded allegations of improper behaviour.
- Assisting in the assessment or procedure, for example handing instruments during an assessment or procedure.
- Assisting with undressing, dressing, and positioning service users.

A chaperone is not used to reduce the risk of attack on a healthcare professional.

There are two main types of Chaperones: 'formal' and 'informal'.

Informal Chaperones

Informal Chaperones are family, friends, or supporters of the service user invited by the service user to accompany them in the consultation. Many service users feel reassured by the presence of a familiar person. Clinicians will accept the service users wish for an informal chaperone in almost all cases. The shortcomings of utilising informal chaperone include:

- They may not understand the boundaries between appropriate and inappropriate clinician behaviour within an assessment or procedure.
- They may not necessarily be relied upon to act as an independent witness to the conduct or continuing consent of the procedure.

Under no circumstances should a child be expected to act as a chaperone. However, if the child is providing comfort to the parent and will not be exposed to unpleasant experiences it may be acceptable for them to stay. It is inappropriate to expect an informal chaperone to assist in or take part in the assessment or to witness the procedure directly.

Formal Chaperones

A 'formal' chaperone implies a staff member, trained as a chaperone. This person may be a receptionist, nurse, or a healthcare assistant. This individual will have a specific role to play in terms of the consultation and this role should be made clear to both the service user and the chaperone. Chaperones must have sufficient training to understand the role expected of them and they must not be expected to undertake a role for which they have not been trained.

Protecting the service user from vulnerability and embarrassment means that the chaperone will usually be of the same gender as the service user. There may be occasions when no staff of the same gender as the service user are available. On any such occasion, provided it is clinically appropriate to delay the assessment / procedure, the service user will be offered the option to rebook for the assessment / procedure at a time when a clinician of their choice is available.

The service user always has the opportunity to decline a particular person as a chaperone if that person is not acceptable to them for any justifiable reason.

Offering a chaperone

The relationship between a service user and their prosthetist/orthotist is based on trust. A prosthetist/orthotist may have known a service user for a long time; however a chaperone should always be offered in all circumstances that meet the criteria outlined in this document, regardless of how long the service user is known to the prosthetist/orthotist. Therefore, all service users have equity of access to chaperones in identical clinical situations. Any service user is entitled to a chaperone if they feel one is required.

All prosthetists and orthotists should be aware that intimate assessments might cause anxiety for both male and female service users, whether the examiner is of the same gender as the service user. It is good practice to offer all service users a choice of the gender of their chaperone for their assessment or procedure. If the service user is offered and does not want a chaperone it is important to record that the offer was made and declined.

An intimate assessment can include assessments of the genitalia e.g. for assessment of inguinal hernias but it also extends to any assessment where it is necessary to touch or be close to the service user; for example, conducting physical assessments or casts of the body.

If a chaperone is refused, a prosthetist/orthotist cannot usually insist that one is present. However, there may be cases where the prosthetist/orthotist makes a professional judgement that they cannot conduct the assessment or procedure without a chaperone present and may decline to proceed without a chaperone. Examples include where the prosthetist/orthotist considers there is a significant risk of the service user experiencing distress, displaying unpredictable behaviour, or making false accusations. In any such case, the prosthetist/orthotist must make his/her/their own decision and carefully document their decision and rationale in the notes along with the details of any assessment/procedure undertaken.

Where a chaperone is needed but not available

If the service user has requested a chaperone and none are available at that time the service user must be given the opportunity to reschedule their appointment within a reasonable time frame (this may include waiting in the department until a member of staff is available). If the urgency of the presenting condition or issue dictates that a delay is inappropriate, then this should be explained to the service user and recorded in their notes. A decision to continue or otherwise must be jointly reached.

In cases where the service user is not competent to make an informed decision then the prosthetist/orthotist must use their own clinical judgement and be able to justify their course of action. The decision and rationale should be documented in the service user's notes.

Issues specific to children

Children and their parents or guardians must receive an explanation of the planned assessment / procedure in order to obtain their informed consent, co-operation and understanding.

Issues specific to religion, ethnicity, culture, and sex

All service users undergoing assessments should be allowed the opportunity to limit the degree of nudity by, for example, uncovering only that part of the anatomy that requires investigation. Some service user's ethnic, religious, cultural background, and sexual orientation can make intimate assessments particularly difficult. For example, service users may have a strong cultural, religious, or belief system resulting in them being averse to assessments by clinicians of the opposite gender. A service user might prefer a prosthetist / orthotist of the same or opposite sex.

The service user's beliefs, attitudes, and concerns must not be presumed and must be discussed with the service user and taken into account. Each individual has very different needs and before the procedure these should be mutually agreed with the prosthetist/orthotist. The prosthetist/orthotist however will not collude with service users who are practising discrimination.

Issues specific to people with learning difficulties and mental health problems

For service users with learning difficulties or mental health problems that affect capacity, a familiar individual such as a family member or carer may be the best chaperone. A simple and sensitive explanation of the assessment is vital.

Adult service users with learning difficulties or mental health problems who resist an assessment or procedure must be interpreted as refusing to give consent and the procedure must be abandoned. Advice and assistance are available from the Vulnerable Adults Support and Safeguarding teams and for mental health service users specialised advice and support can be sought from the Mental Health Care Team.

Non-English speaking service users

If a non-English speaking service user is examined, an independent interpreter should be enlisted. This will help ensure the service user understands the proposed assessment / procedure and is able to grant (or decline to grant) informed consent. The interpretation service is usually provided over the telephone. The use of a formal chaperone may still be appropriate even if the interpreter is in the room as the interpreter may not be a trained chaperone. A family member or interpreter should not be used as a formal chaperone.

Lone working

Where a prosthetist/orthotist is working in a situation away from other colleagues, for example during a home visit, the same principles for offering and use of chaperones should apply. The prosthetist/orthotist may be required to risk assess the need for a formal chaperone and should not be deterred by the inconvenience or complexity of making the necessary arrangements. In all instances the outcome must be documented.

Service user confidentiality

In all cases where the presence of a chaperone may intrude in a confidential clinician-service user relationship their presence should be confined to the physical assessment. Confidential communication between the prosthetist/orthotist and the service user should, where possible, take place before and after the assessment or procedure when confidentiality is easier to maintain.

Communication and record keeping

The key principles of communication and record keeping will ensure that the prosthetist/orthotist and service user relationship is maintained. This will assist service user comfort and dignity, their confidence in the professionalism of the clinician and practice, and also safeguard the clinician against formal complaints, or in extreme cases, legal action.

The most common cause of service user complaints is a failure in communication between both parties, either in the clinician's explanation of, or the service users understanding of, the process of assessment or treatment. It is essential that the prosthetist/orthotist explains the nature of the assessment and offers service users a choice whether to continue. Chaperoning in no way removes or reduces this responsibility.

Details of the assessment including the presence or absence of a chaperone and the information given must be documented in the service user's clinical record. The records should make clear from the history that the assessment was necessary.

In any situation where concerns are raised or an incident has occurred this should be dealt with immediately in accordance with the local Incident Reporting Procedure.

Key points to remember:

- Inform your service users of the practice's chaperone policy.
- Record the use, offer, and declining of a chaperone in the service user's notes.
- Ensure training for all chaperones.
- Be sensitive to a service user's ethnic/religious and cultural background. The service user may have a cultural dislike to being touched by a man or woman or undressing.
- Do not proceed with an assessment if you feel the service user has not understood due to a language barrier.

Regardless of the service user's role, it is always the clinician's responsibility to manage and maintain professional boundaries – utilising chaperones effectively is a way of managing relations with service users, where the ultimate responsibility for ensuring that relations remain on professional footing rests with you.

The service user must be made fully aware of the purpose of any imaging or recording that they have consented to and how it will be used.

A documented record of all images or recordings taken must be maintained. Local policies should be consulted, as written consent is often required.

Key points to remember

When treating a young person

Sometimes, the person with parental responsibility may not wish to be in the room during treatment. In this situation, they must be in the room when the proposed treatment is discussed and have consented to the proposed procedure unless you are relying on Gillick Competency. If they subsequently decide to leave the room, you may only proceed if you are chaperoned, preferably by another adult known to the child remaining in the room or an official Chaperone as per the Chaperone Policy within your local Trust/Health Board or company under whom you are working.

When treating a vulnerable adult

It may not be advised to treat a vulnerable adult completely on your own for safeguarding reasons. BAPO would suggest you consider whether the service user should be accompanied for their assessment/appointment. If this is not possible/practicable for example due to them living on their own; just be aware of their vulnerability and consider whether a risk assessment should be undertaken. Record you decision making process in the service user notes. If the service user requests a chaperone, then follow the Chaperone Policy within your local Trust/ Health Board or company under whom you are working.

Removal of articles of clothing

There are times when a clinical assessment, casting/measuring, or fitting appointment will require the removal of certain items of clothing. You will have to carefully consider the justification for making such a request. No request should be made where the proposed test or reason for removing clothing does not inform or direct the diagnosis or treatment. Clothing should only be removed with prior consent. If clothing needs to be removed from a child, the person with parental responsibility must be present. If main clothing (e.g. trousers) need to be removed and shorts put on, let the person with parental responsibility do this if the child cannot and leave the room whilst they do so.

Preventing unsuitable people working with children and vulnerable adults

All prosthetic and orthotic services need to operate safe recruitment practices, which includes ensuring appropriate disclosure and reference checks are undertaken. In England and Wales, Disclosure and Barring Service (DBS) checks should be undertaken. In Scotland, Disclosure Scotland provides Protecting Vulnerable Groups (PVG) checks and for Northern Ireland an Access NI criminal record check should be undertaken.

The services must ensure that any disciplinary proceedings against staff relating to child and/or vulnerable adult safeguarding matters are concluded in full even when the member of staff is no longer employed within a service, and that notification of any concerns is made to the relevant authorities including the HCPC, and included in references where applicable.

"Make every contact count: Safeguarding is everybody's business, and your part is vital."

Do:

Consider barriers people face that are experiencing abuse and neglect-trust issues, fear of reprisal, shame, guilt, carer fatigue/ stress.

Consider who to escalate your concern to for further advice, and support where needed.

Do not:

Let your attitudes, assumptions and cultural norms cloud your judgements and concerns (Unconscious bias).

Take things at face value, question things, escalate, and ask for more information.

Wait for a crisis to emerge, be proactive to work together to prevent abuse or neglect from occurring or getting worse.

Always consider the four Rs for all clinical judgement:

Recognise

- Is the service user at risk or experiencing harm, abuse, neglect?
- Did the service user sustain an injury? Think about preserving evidence.
- What type of abuse is the adult at risk from?
- Does the person need care and/or support?

Respond

- Is emergency support required to ensure safety?
- Seek consent to refer where the service user is capacious.
- Remain non-judgemental.
- Do not confuse confidentiality with secrecy (Caldicott).
- Are there children/ other service users at risk?
- Use an interpreter if appropriate.

Report & Record

- What type of report is required? (Acute, Community, or Staff)
- What is the process?
- Clear documentation in notes and on the referral form.

Safeguarding is everyone's business and responsibility.

You are accountable for what you do or choose not to do.

Management of allegations

All prosthetic and orthotic staff (both clinical and non-clinical) have a responsibility to report if they believe or have a concern that a member of staff is using unacceptable behaviour to an adult with care and support needs or a child/young person.

All members of staff have a duty to identify, and report concerns about the conduct and professional performance of other colleagues at the earliest possible stage to safeguard the welfare of service users.

All members of staff should be alert to the possibilities that individual performance could be the result of wider system problems and should escalate their concerns and act quickly.

What is an allegation?

An allegation relates to a situation where an adult with care and support needs or a child/young person, is suffering or is likely to suffer harm from an employee of the Trust/Health Board or other organisation.

An allegation will also include situations where an employee has:

- Behaved in a way which has harmed or may have harmed an adult with care and support needs or a child/young person.
- Possibly committed a criminal offence against or related to an adult with care or support needs or a child/young person.
- Behaved in a way that deems them unsuitable to work with adults with care and support needs or a child/young person.

An allegation may come from a service user, carer, another staff member, or an external agency. Information may come to light about a staff member's behaviour out of work which could indicate a breach in professional conduct.

Actions to take:

1. Ensure service user safety.
2. Obtain information about the nature of the allegation.
3. Take any information seriously.
4. Contact your line manager.
5. Report the allegation via the relevant HR processes.
6. Allegations Manager/HR will advise on way forward in consultation with the safeguarding leads.
7. Safeguarding Children Lead to notify the Local Authority Designated Officer (LADO) of any cases involving children.
8. Safeguarding Leads will advise on any referrals to Social Care.
9. Provide support to the person that has raised the allegation and the person to whom the allegation has been raised.

Prevent

The Government's Counter-terrorism Strategy is called **CONTEST** and it is divided into four priority objectives:

- **Pursue:** stop terrorist attacks.
- **Prepare:** where we cannot stop an attack, mitigate its impact.
- **Protect:** strengthen overall protection against terrorist attacks.
- **Prevent:** stop people becoming terrorists and supporting violent extremism.

Prevent operates in the pre-criminal space, before any criminal activity has taken place. It supports and protects people who might be susceptible to radicalisation, ensuring that individuals are diverted away before any crime is committed.

The importance of Prevent strategy in the NHS

Prosthetists and orthotists may meet and treat people who are vulnerable to radicalisation. People with mental health issues or learning difficulties may be more easily drawn into terrorism.

Radicalisation is usually a process not an event. During that process, behaviours as well as opinions are likely to change. These changes may be apparent to the friends, families, and work colleagues of the person concerned.

Changes could include unusual changes in behaviour; accessing of violent extremist material online; use of extremist or hate terms to exclude others or incite violence; writing or artwork promoting violent extremist messages or images.

What factors might make people vulnerable to exploitation?

Some of the factors that can contribute to the vulnerability of individuals and could put them at risk of exploitation by radicalisers are:

- Identity crisis.
- Personal crisis.
- Personal circumstances.
- Unemployment or under employment.

Emotional signs of radicalisation/extremism may include:

- Depressed, withdrawn, or moody and become aggressive or prone to anger easily.
- Stop participating in their usual activities. Lose interest in previous activities or friends.
- Develop a conviction that their religion, culture, or beliefs are under threat and treated unjustly.
- Preoccupied with feelings of hatred or anger about particular mainstream or minority groups.

Verbal signs of radicalisation/extremism may include:

- Sudden change in language or use of words (scripted speech or speaking the words of others and fixated on a certain subject).
- Asking inappropriate questions, argumentative, and less tolerant of other people views.
- Using language that supports 'us and them' thinking and promoting the use of violence as a means to an end.

Physical signs of radicalisation/extremism may include:

- New friendship groups and change of dress or style to accord with a new group.
- Have possession of materials, tattoos, or symbols associated with an extremist view.
- Possess or be searching for extremist literature online, or be secretive about their internet interests.
- Sudden changes to their routine and have unexplained absences or trips away.
- Go missing from their home, school, or care setting.

If you are concerned that a young person or an adult may be radicalised, make a referral to the local Safeguarding Adults or Safeguarding Children teams who will liaise with 'Channel', which is a supportive multi-agency process designed to safeguard those individuals who may be vulnerable to being drawn into any form of terrorism. Channel is part of the Prevent strand of Government's Counter Terrorism Strategy.

Modern slavery and trafficking

Modern slavery (Modern Slavery Act 2015) encompasses:

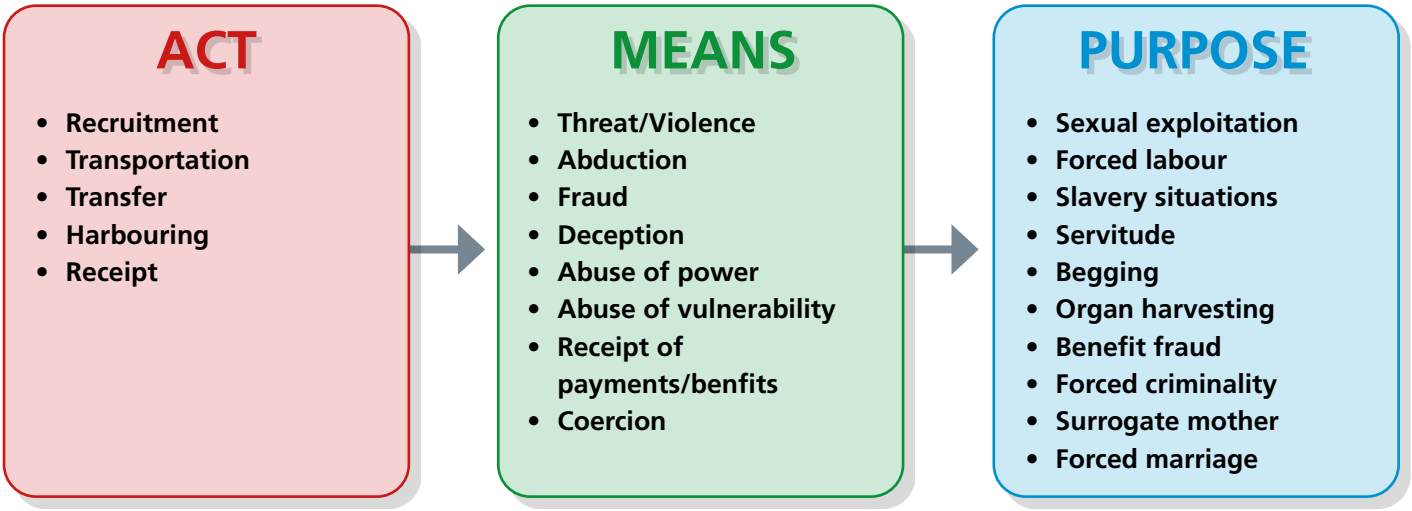
- Human trafficking, which occurs when victims are taken between countries or around a country so they can be exploited, and
- Slavery, servitude, and forced or compulsory labour.

Some people may not be victims of human trafficking but are still victims of modern slavery. Indicators include:

- Often looking injured and malnourished. Has old or serious injuries left untreated.
- Provides vague information and is reluctant to explain how injury occurred.
- A lack of belongings.
- Avoiding eye contact and reluctance to talk to strangers.
- Fearful, anxious, or distrustful.
- Accompanied by someone who appears controlling, who insists on giving information and speaking for them.
- Withdrawn and submissive, seems afraid to speak to anyone in authority.
- Provides vague and inconsistent explanations of where they live, employment, or schooling.
- Not registered with a GP, nursery, or school.
- Appears to be moving location frequently.
- Has no official means of identification or has suspicious looking documents.

If you are concerned of modern slavery or human trafficking, consider the following:

- Human Trafficking = **ACT** + **MEANS** + **PURPOSE**
- Child Trafficking = **ACT** + **PURPOSE**
- Modern Slavery = **MEANS** + **PURPOSE**



If you are concerned a service user is at risk or being exploited, please make a referral to the local Safeguarding Adults or Safeguarding Children Team (depending on age), or contact the National Modern Slavery Helpline on 08000 121 0700.

Related safeguarding issues

Mate crime

This occurs when an adult at risk is befriended by member(s) of the community who go on to exploit and take advantage of them. This form of crime can be carried out by someone the adult knows and often happens in private. Mate crime is ambiguous in nature, but should be reported to the police who will make a decision about whether or not a criminal offence has been committed.

Euthanasia/Assisted Suicide

Euthanasia is the act of deliberately ending a person's life to relieve suffering, where assisted suicide is the act of deliberately assisting or encouraging another person who commits, or attempts to commit, suicide. Both euthanasia and assisted suicide are illegal under English law.

Depending on the circumstances, euthanasia is regarded as either manslaughter or murder and is punishable by law with a maximum penalty of up to life imprisonment.

Assisted suicide is illegal under the terms of the Suicide Act (1961) and is punishable by up to 14 years' imprisonment. Attempting suicide is not a criminal act in itself.

"Honour-based" violence

Honour-based violence (HBV) is the term used to refer to a collection of practices used predominantly to control the behaviour of women and girls within families or other social groups in order to protect supposed cultural and religious beliefs, values, and social norms in the name of 'honour'.

Honour-based violence includes:

- Forced marriage.
- Domestic violence (physical, sexual, emotional, or financial abuse).
- Sexual harassment and sexual violence (rape and sexual assault or threat of rape and sexual assault).
- Threats to kill.
- Social ostracism or rejection and emotional pressure.
- Denial of access to children.
- Pressure to go or move abroad.
- House arrest and excessive restrictions of freedom.
- Denial of access to the telephone, internet, or passport/key documentation.
- Isolation from friends and own family.

Refuge has a Freephone 24-Hour National Domestic Abuse Helpline: 0808 2000 247 or visit www.nationaldahelpline.org.uk (access live chat Mon-Fri 3-10pm).

Forced marriage

Forced marriage is where one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) consent to marriage as they are pressurised, or abuse is used, to force them to do so.

It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights.

Forced Marriage is a crime and is not specific to one culture or country. The Forced Marriage Unit (FMU) provide advice and support related to possible forced marriage.

Discrimination and hate crime

Discrimination is when an individual is treated unfairly because of who they are, or what they believe. Discrimination can come in one of the following forms:

- **Direct discrimination:** Treating someone with a protected characteristic less favourably than others.
- **Indirect discrimination:** Putting rules or arrangements in place that apply to everyone, but that put someone with a protected characteristic at an unfair disadvantage.
- **Harassment:** Unwanted behaviour linked to a protected characteristic that violates someone's dignity or creates an offensive environment for them.
- **Victimisation:** Treating someone badly for a protected act including:
  - making a claim or complaint of discrimination (under the Equality Act).
  - helping someone else to make a claim by giving evidence or information.
  - making an allegation that you or someone else has breached the Equality Act.
  - doing anything else in connection with the Equality Act.

Hate crimes are crimes that are motivated by prejudice of some kind. These are crimes where the victim is targeted because they are a member of a particular social group or have a particular characteristic, which the perpetrator has negative views or beliefs about.

The legal definition is:

> *"Any crime which is understood by the victim or any other person as being motivated (wholly or partly) by malice or ill will towards a social group."*

With the introduction of the Hate Crime and Public Order Act (2021), the law recognises crimes motivated by prejudice based on someone's:

- Age
- Disability (including physical disability, learning disability, and mental health difficulty)
- Sex/Gender
- Race (including nationality, ethnicity, and skin colour)
- Religion or belief
- Sexual Orientation
- Gender reassignment/Transgender identity
- Variations in sex characteristics
- Marriage and civil partnerships
- Pregnancy and maternity

These groups suffer disproportionately as victims of harassment and crime and much of this is motivated by prejudice. In addition to the effect on the individuals experiencing the hostility, these incidents create mistrust and suspicion between communities. This makes hate crime an issue for every service and every community.

Everyone has a role to play in stopping hate crime. If an incident is perceived by the victim – or any other person – as being motivated by prejudice or hate, then it should be reported as a hate crime.

What is a hate crime?

A crime is an act that breaks the law. Any crime has the potential to be a hate crime, especially if it involves one or more of these:

- Offensive language (including name calling and insults).
- Abusive verbal or written comments which are meant to threaten and intimidate (including through email, social networks, and mobile phone messages).
- Physical assault.
- Domestic violence.
- Financial exploitation.
- Vandalism or criminal damage to your property (including graffiti).
- Sexual abuse and assault.
- Threats, intimidation, humiliation, or degradation.

It's important to remember that a victim does not have to be a member of the group the hostility is targeted at. In fact, anyone could be a victim of a hate crime. For example, you could be called a homophobic slur, even if you're heterosexual.

When is hate an incident?

A hate incident is any incident (which may or may not be a crime) that the victim or any other person believes is motivated by hostility or prejudice towards any aspect of the victim's identity. Hate incidents can feel like crimes to those who suffer them and often escalate to crimes or tension in a community. Hate incidents should be reported just as hate crimes are.

Why should a hate crime be reported?

- To stop it from getting worse.
- To stop it from happening to others.
- To help identify the offenders.
- To make your community safer.

Anybody can report a hate crime – whether they're the victim, someone who saw the crime, or someone (such as, the victim) has talked about the crime or incident.

If someone's life is in danger, or a serious crime is taking place, you should always call the police immediately using 999.

In all other cases, you can contact the police on 101 and make sure you say that you believe it's a hate crime.

How do I know if it's a hate crime or hate incident?

Some examples of hate incidents include:

- Verbal abuse, including name-calling and offensive jokes.
- Harassment.
- Bullying or intimidation by children, adults, neighbours, or strangers.
- Physical attacks such as hitting, punching, pushing, spitting.
- Threats of violence.
- Hoax calls, abusive phone or text messages, hate mail.
- Online abuse, for example on Facebook or X.
- Displaying or circulating discriminatory literature or posters.
- Harm or damage to things such as your home, pet, or vehicle.
- Graffiti.
- Arson.
- Throwing rubbish into a garden.
- Malicious complaints, for example over parking, smells, or noise.

When hate incidents become criminal offences they are known as hate crimes. A criminal offence is something that breaks the law. Some examples of hate crimes include:

- Assaults
- Criminal damage
- Harassment
- Murder
- Sexual assault
- Theft
- Fraud
- Burglary
- Hate mail
- Harassment

Race and Religious Hate Crime

Racist and religious crime is particularly hurtful to victims as they are being targeted solely because of their personal identity: their actual or perceived racial or ethnic origin, belief or faith. These crimes can happen randomly or be part of a campaign of continued harassment and victimisation.

Homophobic and Transphobic Hate Crime

In the past, incidents against lesbian, gay, bisexual people, and transgender people have been rarely reported and even more rarely prosecuted. Research studies suggest that victims of, or witnesses to, such incidents have very little confidence in the criminal justice system.

Disability Hate Crime

Feeling and being unsafe through violence, harassment, or negative stereotyping has a significant impact on disabled people's sense of security and wellbeing. It also impacts significantly on their ability to participate both socially and economically in their communities.

The Crown Prosecuting Service sets out their policy on all of the above crimes and provides further information, with further support available from the **Citizens Advice Bureau**.

Duty of candour

The duty of candour is a general duty to be open and transparent with people receiving care from you.

Statutory and professional duties of candour

There are two types of duty of candour, statutory and professional.

Both the statutory duty of candour and professional duty of candour have similar aims: to ensure that those providing care are open and transparent with the people using their services, whether or not something has gone wrong.

Saying sorry is not admitting fault

A crucial part of the duty of candour is the apology. Apologising is not an admission of liability. This is the case, regardless of whether you are in health or social care, or public or private sectors.

In many cases it is the lack of timely apology that pushes people to take legal action. To fulfil the duty of candour, you must apologise for the harm caused, regardless of fault, as well as being open and transparent about what has happened.

NHS Resolution is the organisation that manages clinical negligence claims against the NHS. Their 'Saying Sorry' leaflet confirms that apologising will not affect indemnity cover: Saying sorry is:

- always the right thing to do
- not an admission of liability
- acknowledges that something could have gone better
- the first step to learning from what happened and preventing it recurring.

Notifiable safety incidents

A notifiable safety incident is a specific term defined in the duty of candour regulation. It should not be confused with other types of safety incidents or notifications.

A notifiable safety incident must meet all three of the following criteria:

1 It must have been unintended or unexpected.
2 It must have occurred during the provision of an activity regulated by the Care Quality Commission (CQC).
3 In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care. This element varies slightly depending on the type of provider.

Health service body

Section 9 of the National Health Service Act 2006 defines a 'health service body'. For the purposes of the duty of candour, a health service body means either an:

- NHS Trust/Health Board.
- NHS Foundation Trust.

Paragraph 8 of Regulation 20 defines these harms: In the reasonable opinion of a healthcare professional, could result in or appears to have:

- resulted in the death of the person - directly due to the incident, rather than the natural course of the person's illness or underlying condition
- led to the person experiencing severe harm, moderate harm, or prolonged psychological harm.

These definitions of harm are linked to the National Reporting and Learning System (NRLS) definitions.

What you must do when you discover a notifiable safety incident

The regulation states that you must:

1 Tell the relevant person, face-to-face, that a notifiable safety incident has occured.
2 Apologise.
3 Provide a true account of what happened, explaining whatever you know at that point.
4 Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5 Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6 Keep a secure written record of all meetings and communications with the relevant person and record on Datix.

Definitions of harm

These definitions are common to all types of service.

Moderate harm

Harm that requires a moderate increase in treatment and significant, but not permanent, harm.

Severe harm

A permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Moderate increase in treatment

An unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an out-service user, cancelling of treatment, or transfer to another treatment area (such as intensive care)

Prolonged pain

Pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged psychological harm

Psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Duty of candour examples can be found in Appendix 4.

Information sharing

Always be aware of the following rules regarding information sharing:

- Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not a barrier to justified sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.
- Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how, and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
- Seek advice from other clinicians, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
- Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information for someone, be clear on the basis upon which you are doing so. Where you do have consent, be mindful that an individual might not expect information to be shared.
- Consider safety and well-being: Base your information sharing decisions on considerations of the safety and wellbeing of the person and others who may be affected by their actions.
- Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.
- Keep a record of your decision and the reasons for it, whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

A brief overview of your responsibilities

Healthcare professionals have a legal and ethical duty to ensure that appropriate consent is obtained before providing care or treatment to a service user. In the UK, this includes confirming that the individual accompanying a child to an appointment has parental responsibility or is otherwise legally authorised to consent to the proposed treatment or examination.

It is the responsibility of healthcare professionals to:

1. **Determine Parental Responsibility**
   Verify that the accompanying adult has legal parental responsibility, particularly where consent is required for examination or treatment. Parental responsibility is defined under the Children Act 1989 and may rest with a parent, legal guardian, or another individual as determined by a court order or legal agreement.

2. **Obtain Valid Consent**
   Ensure valid, informed consent is obtained before any examination, investigation, or treatment is initiated. For children under the age of 16, consent must generally be given by someone with parental responsibility unless the child is assessed to be Gillick competent and capable of understanding the implications of the treatment themselves. (Please read BAPO's comprehensive guide to clinical record keeping, data protection, confidentiality, and consent for more information).

3. **Safeguarding Responsibilities**
   Be alert to any safeguarding concerns, including inconsistencies in the accompanying adult's relationship with the child or dependent adult, signs of abuse or neglect, or failure to provide an appropriate adult to attend. Any concerns must be documented and escalated in accordance with local safeguarding procedures and national guidelines, including Working Together to Safeguard Children (2018).

Healthcare professionals must remain vigilant in applying these responsibilities to uphold the safety, rights, and welfare of the service user in all clinical interactions.

Further reading

Assessing capacity and deprivation of liberty safeguards (DoLS)

- British Medical Association. Assessing mental capacity.
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- Community Care. DoLS replacement bill becomes law ahead of expected implementation in 2020.
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- Department of Health. Everyone is equal. Know your rights.
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- General Medical Council. Capacity issues.
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- Care Quality Commission. Deprivation of Liberty Safeguards: Code of Practice.
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- Care Quality Commission. Deprivation of Liberty Safeguards: State of Care 2022/23.
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  Available at: www.scie.org.uk/mca/
- Social Care Institute for Excellence. Deprivation of Liberty Safeguards. Available at: www.scie.org.uk/mca/dols and www.scie.org.uk/mca/dols/at-a-glance

Northern Ireland:

- Department of Health. Deprivation of Liberty (DoLS) Interim Guidance.
  Available at: www.health-ni.gov.uk/publications/deprivation-liberty-safeguards-dols-–-interim-guidance
- Legislation.gov.uk. Mental Capacity Act (Northern Ireland) 2016.
  Available at: www.legislation.gov.uk/nia/2016/18/pdfs/nia_20160018_en.pdf
- Northern Ireland Assembly. Mental Capacity Bill: Deprivation of Liberty Safeguards.
  Available at: www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/hssps/9615.pdf

Scotland:

- Quality Compliance Systems. Deprivation of liberty legislation in Scotland.
  Available at: www.qcs.co.uk/deprivation-liberty-legislation-scotland/
- Royal College of Anaesthetists. Guidance on mental capacity in other parts of the UK.
  Available at: https://rcoa.ac.uk/documents/consent-ethics-adults/guidance-mental-capacity-other-parts-uk
- Scottish Government. Adults with Incapacity (Scotland) Act 2000.
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- Social Care Wales. The mental capacity act and deprivation of liberty safeguards (DoLS).
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Chaperoning

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- The British Association of Prosthetists and Orthotist. A comprehensive guide to clinical record keeping, data protection, confidentiality, and consent
  Available at: www.bapo.com/resources/bapos-standards-policies-and-guides/

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- Alzheimer's Society. Delerium – symptoms, diagnosis and treatment.
  Available at: www.alzheimers.org.uk/get-support/daily-living/delirium#:~:text=Types%20of%20delirium,mixed%20delirium%20are%20most%20common
- British Geriatrics Society. Dementia, delirium and brain health.
  Available at: www.bgs.org.uk/dementia-delirium-and-brain-health
- Dementia UK. What is dementia?
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Looked after children

- Royal College of Nursing on behalf of the Royal College of Paediatrics and Child Health. Looked after Children: roles and competencies of healthcare staff.
  Available at: www.rcn.org.uk/Professional-Development/publications/rcn-looked-after-children-roles-and-competencies-of-healthcare-staff-uk-pub-009486
- Ethnic and cultural bias and child protection services: Summary of the Child Safeguarding Practice Review Panel's report on race, racism and safeguarding children
  Available at: https://learning.nspcc.org.uk/research-resources/2025/summary-child-safeguarding-practice-review-panel-briefing-race-racism

Reasonable adjustments

- NHS England.
  Available at: www.england.nhs.uk/learning-disabilities/improving-health/reasonable-adjustments/
- BAPO Reasonable Adjustments: A guide for the workplace.
  Available at: www.bapo.com/edi/

Appendix 1

Example safeguarding statement for private clinicians

[Insert Practice Name] Safeguarding Children and Vulnerable Adults Statement
[Insert Practice Name] believes that it is always unacceptable for anyone to experience abuse of any kind and recognises its responsibility to particularly safeguard the welfare of all children, young people and vulnerable adults, by a commitment to practice and behaviour which protects them.

We recognise that:
- The welfare of the child/young person/vulnerable adult is paramount.
- All service users, regardless of age, disability, gender, racial heritage, religious belief, sexual orientation, or identity, have the right to equal protection from all types of harm or abuse.
- Working in partnership with children, young people, vulnerable adults and their parents/guardians, carers and other agencies is essential in promoting service user welfare.

The purpose of the policy:
- To provide protection for the children, young people and vulnerable adults who receive [Insert Practice Name] services, including the children of adult service users or users.
- To provide staff, associates, and learners with guidance on procedures they must adopt in the event that they suspect a child, young person or vulnerable adult may be experiencing, or be at risk of, harm.

This policy applies to all staff, including the practice manager, paid staff, associates, volunteers, and sessional workers, agency staff, learners or anyone working on behalf of [Insert Practice Name] within a premise which is the responsibility of the practice.

We will seek to safeguard children, young people and vulnerable adults by:
- Valuing all people as individuals, listening to and respecting their wishes and needs.
- Adopting the British Association of Prosthetists and Orthotists Safeguarding Children and Vulnerable Adults guide, Code of Ethics, A comprehensive guide to clinical record keeping, data protection, confidentiality, and consent guide, and Standards of Best Practice for all staff, learners, associates, and volunteers.
- Adopting the Health and Care Professionals Council Standards for all staff, learners, associates, and volunteers.
- Recruiting staff and volunteers safely, ensuring all necessary criminal record checks are made.
- Sharing information about child and vulnerable adult protection and good practice with children, parents, service users, carers, staff, associates, and volunteers.
- Reporting information about concerns with agencies who need to know, and involving parents, children, service users' family, and carers appropriately.
- Providing effective management for staff and volunteers through supervision, support and training.

We are also committed to reviewing our policy and good practice annually.

Practice Owner/Managers' Signature: .....

Adopted on: .....

Reviewed date: .....

Appendix 2

Example mental capacity assessment form

The following example provides a simple guide to assessing mental capacity (obtained from Guy's & St. Thomas' NHS Foundation Trust, with kind permission).

Service user's Name:	
Age & Sex:	
Hospital Number:	
NHS Number:	
Address:	

Name of assessor	
Role of assessor	
Contact details of assessor	
Other professionals contributing to assessment	
Setting of assessment	

Clinical decision required	
Details of support provided to the service user to enable them to make the decision themselves	

Stage 1

Is there an impairment of, or disturbance in the functioning of the person's mind or brain that is preventing them from making the decision at this time?

Yes ❑	If yes, please detail what this is:	
No ❑	If no: **THE PERSON'S WISHES SHOULD BE RESPECTED. DO NOT PROCEED WITH THIS ASSESSMENT.**	

If yes to the above, is this impairment or disturbance likely to be temporary or permanent?

Temporary ❑	Justify why temporary:		
Permanent ❑	Justify why permanent:		
If temporary, can the decision wait?	Yes ❑	Justify why the decision can wait:	
	No ❑	Justify why the decision cannot wait:	
If the impairment is temporary and the decision can wait, **DO NOT PROCEED WITH THIS ASSESSMENT.**			

Stage 2

A negative response in any one of the four questions is sufficient to demonstrate lack of capacity.	
Is the person able to understand the information relating to the decision to be made?	Yes ❑ No ❑
Is the person able to retain the information relating to the decision to be made?	Yes ❑ No ❑
Is the person able to use/weigh up the information to enable them to make an informed decision?	Yes ❑ No ❑
Is the person able to communicate their decision?	Yes ❑ No ❑

Outcome

Based on these four questions, does the service user have capacity to make the above decision?

Yes ❑
No ❑

Please explain your responses given in stage 2 and the outcome of your capacity assessment:

Appendix 3

Best interest decisions making flow chart

The following example provides a simple guide to best interest decisions making. Obtained from Guy's & St. Thomas' NHS Foundation Trust, with kind permission.

Date*: Time*:

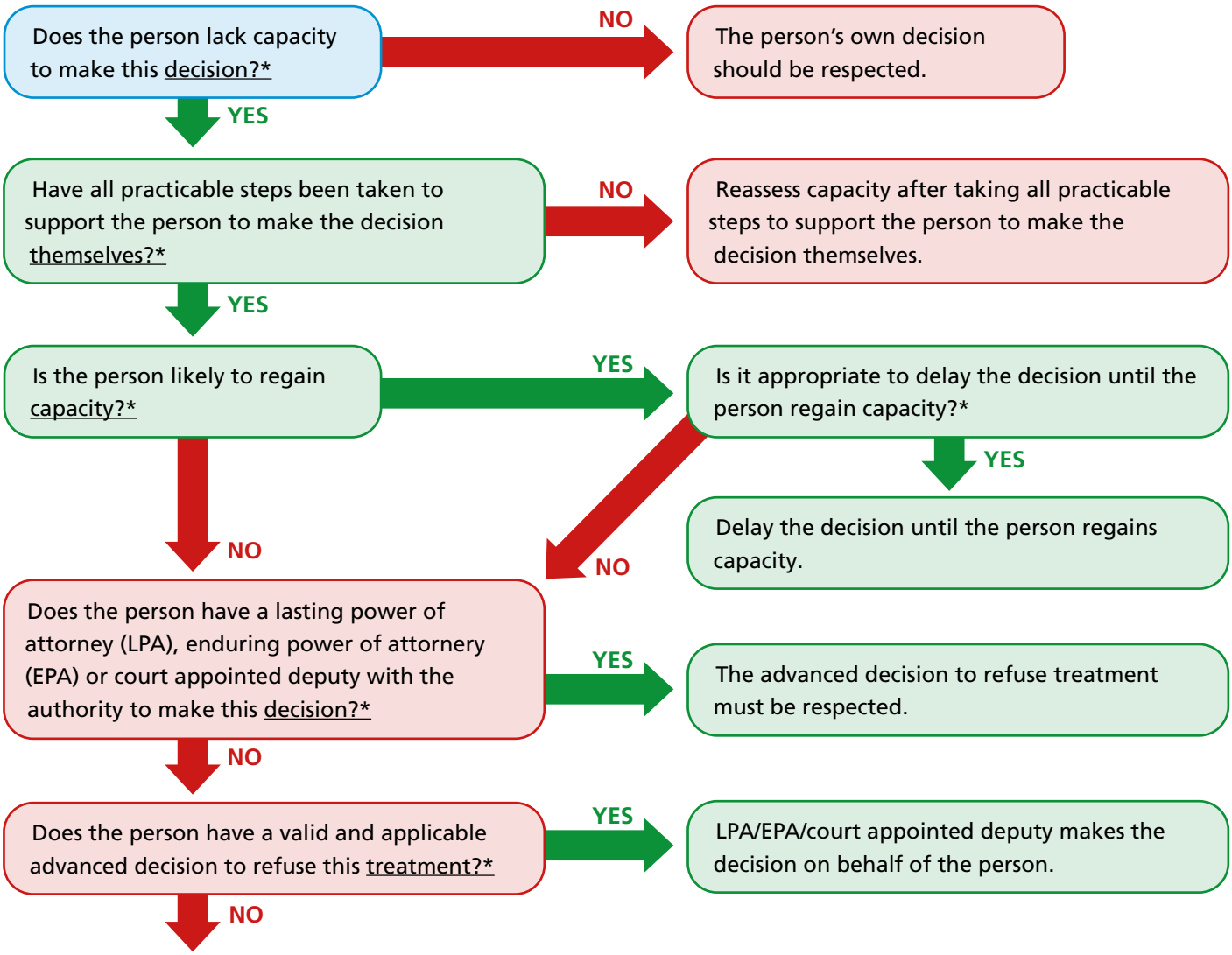
Has a Mental Capacity Assessment form been completed for this decisions?* YES/NO (only proceed if yes)

Select Mental Capacity Assessment*:

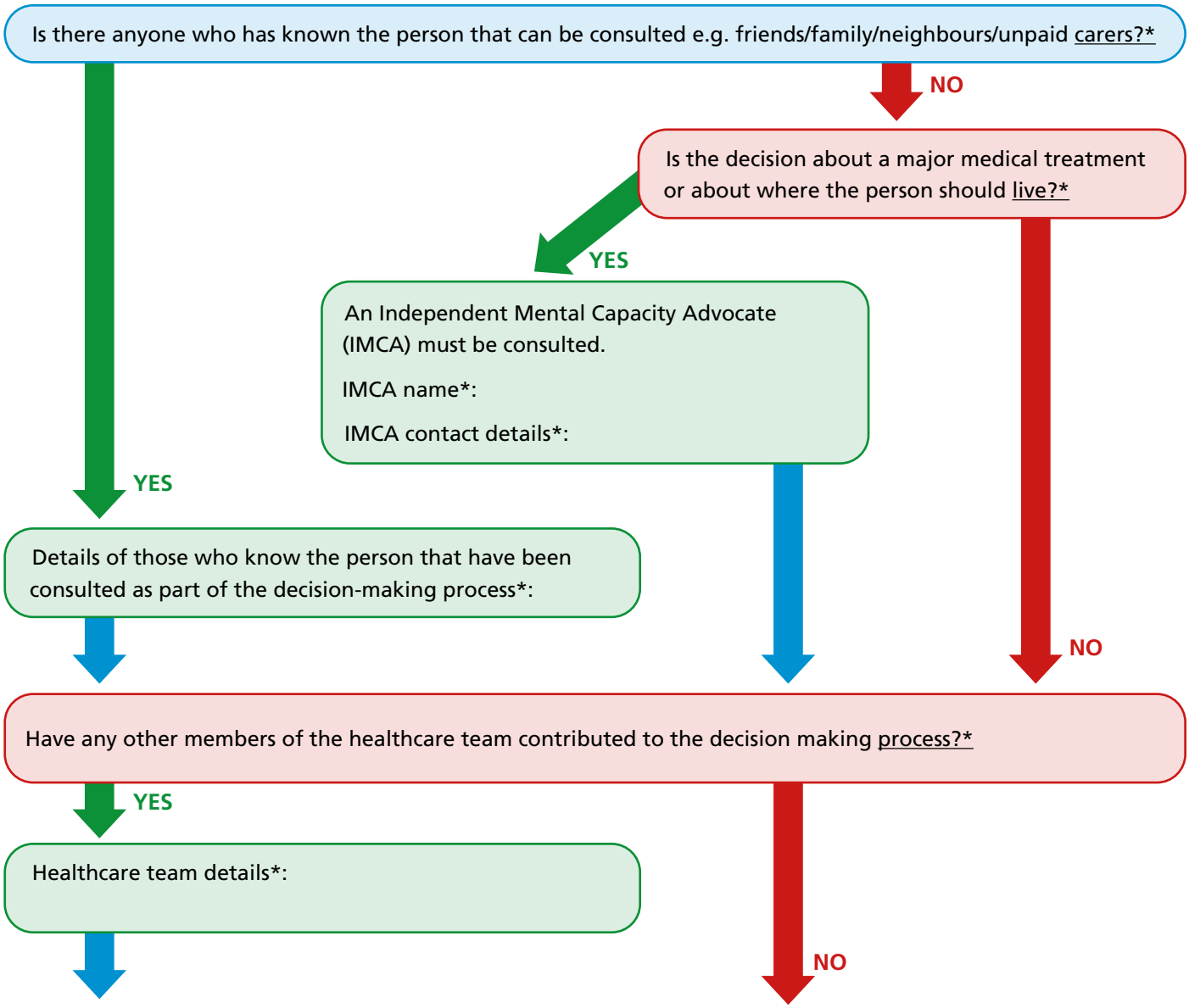
Decision maker/assessor*:

Section 1: The decision to be made

What is the decision that has to be made?*



Section 2: People consulted as part of the decision-making process



Section 3: Options available

List all of the options available to the person relating to the decision in question*:

Section 4: Information gathering

- What steps have been taken to support the person to be able to take part in the decision-making process?
- What are the person's past and present wishes and feelings relating to the decision?
- What are the person's values or beliefs that would be likely to influence the decision in question? (e.g. religious, cultural, moral or political)
- Are there any other factors that the person themselves would likely consider if they were making the decision?
- What are the risks and benefits of each option in turn?
- Are there any other factors that should be considered? E.g. future medical/social/welfare implications of the decision, safety concerns of specific options or how restrictive each option might be.

Record the information that you have gathered as part of the decision-making process*

Section 5: The decision reached in the person's best interests

What is the decision that has been reached and why it is felt to be in person's best interests*?

Section 6: Objections

Has anyone challenged the decision-maker's conclusion?* YES ❑ NO ❑

If yes, how do you intend to proceed?

If someone challenges the decision-maker's conclusions, there are several options:

- Involve an advocate
- Seek a second opinion
- Attempt some form of mediation
- Hold a "best interests" case conference
- They can pursue a complaint through the organisation's formal procedures
- Where all other attempts to resolve the disagreement have failed, consider approaching the Court of Protection

Section 7: Review

Is a review of the decision required*? YES ❑ NO ❑

If yes,

Or describe any circumstances in which a review of the decision would be necessary:

Appendix 4:
Duty of candour: Examples of notifiable safety incidents

It is impossible to cover all the possible events and circumstances that may or may not qualify as notifiable safety incidents.

These case studies provide examples of how to apply the criteria.

Example 1: Maternity

What happened?

A woman in an NHS hospital experienced pain during an elective caesarean section. She found this experience traumatic and subsequently had an acute episode of severe anxiety and depression that lasted more than 28 days. It was discovered that she had been not receiving enough anaesthesia from an epidural line.

Does this qualify as a notifiable safety incident?

1 Was the incident unexpected or unintended? Yes. The incident was both unexpected and unintended.
2 Did it occur during provision of a regulated activity? Yes. The incident occurred while the woman was receiving care under the regulated activity 'maternity and midwifery services'.
3 Has it resulted in death or severe or moderate harm? Yes. The incident has resulted in "prolonged psychological harm" (psychological harm lasting more than 28 days). The woman was receiving care in an NHS hospital so the harm definitions in Regulation 20(8) apply. If the maternity care had been delivered in an independent hospital, Regulation 20(9) would apply instead.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 2: Care home

What happened

An occupational therapist completed an assessment with a care home resident whose mobility was deteriorating. They advised that grab rails were needed in his bathroom before it was safe for him to use the bath, and that in the meantime staff should assist him with a wash each morning. The manager failed to update the man's care plan or inform the care staff of this change, so staff supported him to take a bath the following morning as usual. He slipped when getting out of the bath and broke his arm. The arm was put in a plaster cast and the man needed full assistance for all aspects of his care for six weeks until the cast was removed. He made a full recovery.

Does this qualify as a notifiable safety incident?

1 Was the incident unexpected or unintended? Yes. The incident may not be unexpected, but it is unintended.
2 Did it occur during provision of a regulated activity? Yes. The incident occurred during the provision of the regulated activity 'accommodation for persons who require nursing or personal care'.
3 Has it resulted in death or severe or moderate harm? Yes. The injury in this case is a broken arm and would fall under Regulation 20(9)(b)(ii) as if the injury was left untreated the person using the service could experience one or more of the scenarios referred to in Regulation 20(9)(a)(i) to (v). The person was receiving care in a care home so the definitions in section 9 rather than 8 apply.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 3: Surgery

What happened

An elderly woman undergoes a coronary artery bypass operation. She has given appropriate consent for the risks of the operation, including for stroke and death. Unfortunately, the woman suffers a large stroke during the operation and dies as a result.

Does this qualify as a notifiable safety incident?

1 Was the incident unexpected or unintended? Yes. The incident was a possible risk of the operation, and as such her consent was sought; however the incident was still unintended.
2 Did it occur during provision of a regulated activity? Yes. The incident occurred during provision of the regulated activity 'Surgical procedures'.
3 Has it resulted in death or severe or moderate harm? Yes. The incident resulted in death. The woman was receiving care in an NHS hospital so the definitions in Regulation 20(8) apply. The incident resulted in death.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out. Note that on the facts provided in this example, there is no suggestion of error or fault on the part of the provider. But neither is required for something to qualify as a notifiable safety incident.

Example 4: Mental health

What happened

A prescribing error on a mental health ward resulted in a detained service user being given double her normal dose of lithium for several days. She developed lithium toxicity, which required in-service user admission. She made a full recovery.

Does this qualify as a notifiable safety incident?

1 Was the incident unexpected or unintended? Yes. The incident was both unexpected and unintended.
2 Did it occur during provision of a regulated activity? Yes. It occurred during provision of the regulated activity 'assessment or medical treatment for persons detained under the Mental Health Act 1983'.
3 Has it resulted in death or severe or moderate harm? Yes. The incident resulted in moderate harm as defined in 20(7) (significant, but not permanent, harm, and a moderate increase in treatment). The service user was receiving care in an NHS Trust so the definitions in Regulation 20(8) apply.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 5: Dental

What happened

A child with an unknown allergy to latex went for a dental check-up. The dentist wore latex gloves. The child had a very severe anaphylactic reaction which required hospitalisation. The child made a full recovery.

Does this qualify as a notifiable safety incident?

1 Was the incident unexpected or unintended? Yes. The incident was both unexpected and unintended.
2 Did it occur during provision of a regulated activity? Yes. It occurred during provision of the regulated activity 'diagnostic and screening'.
3 Has it resulted in death or severe or moderate harm? Yes. The incident meant that the person required further treatment to prevent death from anaphylaxis (Regulation 20 (9)(b)(i)). The service user was receiving care in a dentist surgery so the definitions in Regulation 20(9) apply. Note that on the facts provided in this example, there is no suggestion of error or fault on the part of the provider. But neither is required for something to qualify as a notifiable safety incident.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

Example 6: General practice

What happened

A young man fell over while playing badminton and goes to his GP the next day with a swollen and painful foot and ankle. His GP decides not to order an x-ray and sends him home with advice to rest, ice, compress and elevate the leg. He tells the man he can weight bear fully. Over the following week, the pain and swelling does not improve, and the man goes back to the GP surgery and sees a different doctor who sends him for an x-ray. He is found to have a fracture of the base of fifth metatarsal that should have been put into a plaster cast and should have been non-weight bearing. Due to this mismanagement, the service user develops a non-union over the following six weeks which causes him ongoing pain and eventually requires surgical intervention in hospital.

Does this qualify as a notifiable safety incident?

1 Was the incident unexpected or unintended? Yes. The incident was both unexpected and unintended.
2 Did it occur during provision of a regulated activity? Yes. It occurred during provision of the regulated activity 'treatment of disease, disorder or injury'.
3 Has it resulted in death or severe or moderate harm? Yes. The incident resulted in prolonged pain, impairment of motor functions, and the need for surgical intervention. The service user was receiving care in a GP surgery so the definitions in Regulation 20(9) apply.

Conclusion

The answers to all three questions are 'yes'. So this qualifies as a notifiable safety incident. And all steps outlined in the duty of candour (Regulation 20) should be carried out.

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