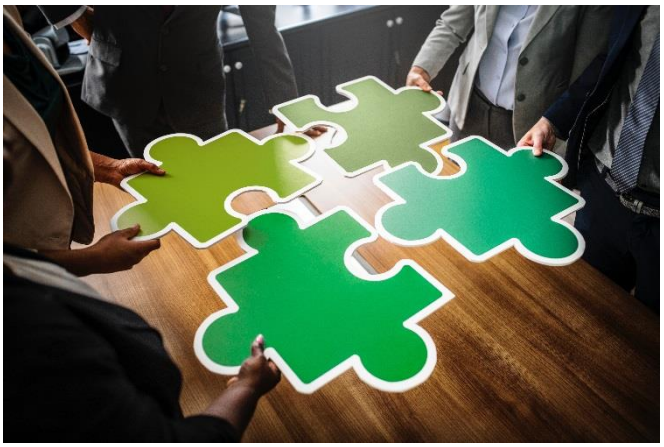
South Gloucestershire Safeguarding Adults Board



Organisational Abuse

Procedures

Updated: June 2021
Review date: June 2023

Acknowledgements

This guidance draws on material, with thanks, from the University of Hull research 2012

Contents

Appendices:

Introduction

This document provides guidance for dealing with concerns in relation to organisational abuse for adults with care and support needs. The guidance recognises that the priority of work in this area is the safeguarding of children and adults. They do not replace existing safeguarding procedures and must be read and used in the context of the South Gloucestershire Multi-Agency Safeguarding Policy and Procedures.

Its purpose is to help staff give better informed and more effective support to people who need an adult safeguarding service because of organisational abuse.

Definition

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect

The Care Act 2014 statutory guidance (14.9) makes it clear that Safeguarding is not a substitute for:

- providers' responsibilities to provide safe and high quality care and support
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action
- the core duties of the police to prevent and detect crime and protect life and property

Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered.

Remember: If it doesn't feel right, it probably isn't. If you have concerns about a person or a service, you should report this.

The Care Act Guidance defines Organisational Abuse as:

Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Not all abuse that occurs within care services will be organisational; some incidents between adults or actions by individual members of staff may occur without any failings on the part of the organisation. Organisational abuse refers to those incidents that derive to a significant extent from an organisation's practice and culture (particularly reflected in the behaviour and attitudes of managers and staff) policies and procedures.

Organisational Safeguarding applies to all services in South Gloucestershire who work with adults with care and support needs, regardless of who is funding their support and regardless of the setting. This guidance applies to all services that support adults who have care and support needs including care homes, domiciliary care services, day care services and hospitals.

Early Indicators of Organisational Abuse

A combination of research and safeguarding practitioner experience has identified a number of elements that could be early indicators of concern. Information and awareness about these early indicators can support practitioners to identify concerns and feel confident that what they have observed is valid, enabling them to act to protect people from abuse. These indicators are detailed in full in Appendix 1. However this is not a definitive list and practitioners may identify other indicators not listed.

The indicators can be grouped into six key themes. These themes provide important information about key aspects of service design and delivery which increase the risks of abuse and harm for people.

The 6 main areas to think about are:

1. Concerns about management and leadership
The people who manage the service and other managers in the organisation. What are they doing, or not doing that might put people at risk of abuse?

2. Concerns about staff skills, knowledge and practice
The people who work in the service. What are their skills and practice like? What are they doing that might put people at the risk of abuse? This is not just people who work as care workers or nursing staff. It could also include the practice of managers and other non-care staff who work in the service.

3. Concerns about adults' behaviours and wellbeing
The people who live in, or use, the service. How are they? Are they behaving in ways which suggest they may be at risk of abuse?

4. Concerns about the service resisting the involvement of external people and isolating individuals
Are the adults cut off from other people? Is it a "closed" or an "open" service? Does the service resist support from external agencies or professionals?

5. Concerns about the way services are planned and delivered
The way in which the service is planned and whether what is actually delivered reflects these plans. Are people receiving the levels of care which have been agreed? Are the adults who use the service a compatible group? Is the service clear about the kind of support it is able to deliver?

6. Concerns about the quality of basic care and the environment
Are basic needs being met? What is the quality of the environment like?

It is important to note:

1. This guide will help practitioners to record, reflect, talk to someone and ACT.

2. It is not necessary for there to be concerns in each of the six key themes, for there to be a concern about a whole service.

3. A pattern of concerns is *not proof* of abuse and **abuse can happen when indicators of concerns are not apparent.**

4. The use of this guide does not replace listening directly to people in services. On the contrary, it gives an important reason to listen more closely before and after concerns are raised.

Whistleblowing

A whistleblowing referral may be the catalyst for identifying wider concerns about a service. Whistleblowing should be distinguished from a complaint in that a whistleblowing referral will be made typically by an employee or an ex-employee of the organisation. The person may or may not have tried to raise the issue with their management. Ideally they should have done but clearly there are times when an employee will feel too intimidated to do so. Where a whistleblowing is actually a safeguarding concern about an individual this should be dealt with initially through individual processes to ensure that the person is safe. Where there are wider implications these may need to be followed up through organisational safeguarding processes.

It is essential that information is taken carefully from whistleblowers whatever their motives appear to be. Just because someone has fallen out with an employer does not necessarily mean that the information they are passing on is not valid. As with any other enquiry this will need to be balanced with other information.

Where the whistleblowing relates to an internal council service, or a service commissioned by the Council, reference should also be made to the corporate guidance – Employee Whistleblowing Policy.

The Care Quality Commission National Customer Service Centre can be contacted on: 03000 616161

Decision making for carrying out Organisational Abuse Enquiries

In addition to the local authority carrying out safeguarding enquiries for individuals living in South Gloucestershire, all safeguarding concerns that are raised about a service provider are logged by the Organisational Safeguarding Team on a separate provider record. These logs are reviewed every three months, or sooner if significant concerns are raised, in order to determine if the decision making process for determining if an Organisational Safeguarding Enquiry is required.

There is a need for professional assessment and judgement in determining when poor practice becomes an adult safeguarding issue. Addressing four key questions will support the decision to initiate screening for an organisational abuse enquiry:

1. Are the concerns of a **type** to indicate organisational abuse?
Do they feature on the Early Indicators of Concern Full Checklist?

2. Are the concerns of a **nature** to indicate organisational abuse?
Is the behaviour widespread or generally accepted within the setting? Is it sanctioned by management and supervisory staff?

3. Are the concerns of a **degree** to indicate organisational abuse?
How long has it been occurring and what is the impact on the adults using the service? Is there a risk of repeated or escalating incidents?

4. Is there a **pattern and prevalence** of concerns about the organisation?
Are the same incidents reported over time or by a number of different agencies?

It is not necessary for all four questions to be answered positively. A one off serious incident may be enough to trigger the decision to consider a service for Organisational Safeguarding.

If the decision is made to carry out the formal decision making process for Organisational Safeguarding then this decision must be documented on the provider record. This process should be carried out within three weeks.

The decision making will include a review of all the concerns and an evaluation of all current sources of evidence, including making enquiries of an appropriate range of services including:

- the previous safeguarding history of the provider (including other services owned by the provider)
- the rating given by the Care Quality Commission – the previous and current status of the service/organisation
- local authority contracts section – previous or current evidence of non-compliance

- local authority feedback team – history of concerns/complaints (and positive feedback)
- police – past or current concerns
- health professionals who may visit e.g. GPs, district nursing, ambulance service, Care Home Liaison, Frailty Team etc. Also if relevant, the history and pattern of referrals to secondary care or emergency department attendances
- practitioner views – any feedback arising from reviews or individual safeguarding enquiries

The decision making will evaluate the issues that are identified under the headings of the six key themes, and will include a recommendation about next steps. This recommendation will be reviewed by the Safeguarding Adults Manager who will decide whether or not to open a formal Organisational Safeguarding Enquiry and record this decision.

If the decision is made not to proceed with an Organisational Safeguarding Enquiry then the Safeguarding Adults Manager should record how the issues arising are to be followed up e.g. by a safeguarding visit to the provider, by the Contracts Section, through individual enquiries, by a visit from another service such as the Clinical Commissioning Group or the Care Quality Commission, or by Adult Social Care Services. The outcome of these actions should be recorded on the service provider's log.

Organisational Safeguarding Enquiries

Partnership Working: Key Points

Responding to organisational abuse is likely to require complex coordination of different organisations both for information and for direct involvement in the enquiry. **Drawing upon the knowledge and expertise of the Councils Care Home Quality Assurance Team, Clinical Commissioning Group, Care Quality Commission and Police partners will be an important early step in formulating an effective approach.** It is important that everyone involved is aware of their respective roles and responsibilities and their duty to cooperate in the enquiry.

As the "host" authority South Gloucestershire Council will lead and co-ordinate large scale enquiries within South Gloucestershire, but multi-agency knowledge, skills and information sharing are essential for best practice, sound decision making and securing positive outcomes for adults.

Who Leads?

The Safeguarding Adults Manager or Senior Practitioner will coordinate all large scale safeguarding enquiries including the chairing of meetings. Exceptionally if this is not possible or the concerns are of a very severe type the Head of Safeguarding* should be consulted and agreement reached about an appropriate chair and co-ordinator. Each participating organisation will nominate a lead to support the enquiry.

Guidance on the relationship between social care and any police/criminal investigation is provided in the South Gloucestershire SAB Policy and Procedures. These will need to be confirmed for each individual enquiry. The balance is between preserving evidence and enabling the police to pursue their investigation and ensuring that all adults are safe within the setting.

The strength of partnership is manifested in each principal safeguarding organisation – in particular, the Council, Police, Clinical Commissioning Group and Care Quality Commission – having a specific role and functions that dovetail to create an effective safeguarding process. Operationally, this requires careful coordination and avoidance of deference to, or dominance of, any single organisational perspective or function.

* South Gloucestershire Council Strategic Safeguarding Manager Catherine Boyce Catherine.boyce@southglos.gov.uk

Active and co-operative behaviour by the service provider is expected and essential. Depending on the type of concerns and the level of staff involved it may or may not be appropriate for the provider to actively make enquiries. This will need to be decided in each situation by the local authority as the body with overall responsibility for the safeguarding enquiry. It will be important to understand the service providers own mechanisms, for example disciplinary procedures, and how any intention to deploy these relates to the safeguarding concern and aligns to the safeguarding plan. It is key that the service provider takes responsibility for the abuse and the impact of it. Where their internal procedures are likely to have set/allowed a culture where abuse can take place it is essential that this become part of the enquiry.

It is essential that where providers are undertaking enquiries arrangements for what these should cover, timescales and how they will be fed back are clear. Where these are not adhered to consideration must be given to how to escalate the concerns to ensure they are managed.

When an investigation involves a number of people who have experienced abuse, or are at risk of abuse, the issues are often complex; involving standards of service as well as a series of individual enquiries.

A large scale enquiry may require a series of individual safeguarding adult enquiries to address allegations of abuse specific to each individual. Under The Care Act 2014, the Local Authority has lead responsibility for adult safeguarding issues however it can delegate responsibility for enquiries to appropriate agencies. In carrying out this responsibility the Chair will co-ordinate the overall enquiry and ensure that all relevant agencies are involved.

Strategic Oversight

In most instances the process outlined below will be sufficiently robust to ensure a full and thorough enquiry can be undertaken and arrangements made to keep people safe. However there may be a small number of situations where it becomes evident that the degree and severity of the safeguarding and the complexity of the situation requires additional strategic oversight. In such instances the host authority will initiate a strategic management group inviting placing authorities, CQC, police, health, legal etc. to identify the most appropriate person to attend. This group would provide oversight to the process ensuring all areas are followed through (see ADASS guidance on Out of Area Safeguarding Adults Arrangements June 2016 for further details).

Key Partners

Police – individual safeguarding concerns forms that require the involvement of the police should be secure emailed to the Lighthouse Safeguarding Unit. The chair of the individual safeguarding enquiry will then liaise with the police as appropriate.

Care Quality Commission - must be informed of any concerns relating to a regulated service.

Local Authority Commissioning & Contracts - must be informed of safeguarding concerns relating to any provider operating in South Gloucestershire, irrespective of whether services are commissioned.

Health - where services are commissioned by the Clinical Commissioning Group, NHS England or public health e.g. via Continuing Health Care (CHC), Funded nursing care (FNCC) or as part of a joint package, the Clinical Commissioning Group must be informed.

Other Local Authorities - where placements are commissioned by another commissioning body for example, another local authority, they should be notified of the referral and involved throughout. While the council retains the lead safeguarding role for all safeguarding concerns, placing commissioning bodies retain a duty of care towards the adult and should be expected to fulfil this role in co-operation with the safeguarding enquiry.

Whether an internally or externally commissioned service, an understanding of the specific contractual requirements of the provider i.e. their own policies and procedures will be an important reference source.

Where safeguarding issues relate to a council provided service (provision or assessment etc.) then care must be taken to ensure that there is a clear separation of interests i.e. all staff involved in the safeguarding enquiry should have no direct relationship to the matters under enquiry.

Depending on the seriousness of the concerns the following will need to happen:

For the most serious situations where serious harm has taken place or is suspected

- the Head of Safeguarding at South Gloucestershire Council must be informed. A decision will then be made about information being passed to senior managers to ensure appropriate involvement and support from services
- where criminal offences may have been committed it is crucial that the first enquiries are done by or with the police
- identify the initial internal resources to co-ordinate and undertake the enquiry/assessment, including legal advice
- organise a strategy meeting to agree an 'Enquiry/Assessment Plan' covering both individual allegations and the organisational setting
- identify and implement a clear communication strategy
- ensure the potential need for advocacy informs the enquiry

Organisational Safeguarding Meetings

A strategy meeting should be called as soon as possible by the Safeguarding Manager. Depending on the level of risk and the complexity of the concerns a balance may be needed between ensuring the maximum number of partners round the table and ensuring people's immediate safety. Where the situation is extremely serious an immediate strategy meeting/discussion may be required to start the enquiry process. This should be a rare occurrence but it is expected that all partners will respond when this is required.

The strategy meeting will need to undertake a preliminary risk assessment based upon existing knowledge and agree an interim safeguarding plan covering both individual concerns and the care setting. This must include a plan to keep existing adults safe. The interim risk assessment should also include the option of suspending further placements.

Follow up meetings will be needed to ensure that actions are followed up and plans revised as required. Including:

- implementation of the enquiry / assessment plan
- report(s) completed by investigator(s)
- evaluation of enquiry /assessment activity and evidence obtained
- determine if abuse/neglect has taken place covering both individual concerns and the care setting (organisational abuse)
- consider the circumstances and potential needs of perpetrator(s)
- agree an ongoing Safeguarding Plan which is likely to have both short and medium term actions
- agree time scales for review of Safeguarding plan
- agree circumstances where re-evaluation of the situation will be required
- agree an action plan for the service provider
- monitoring and review of the action plan for the service provider
- debrief and consider learning points and wider implications
- receive feedback of follow up by provider e.g. disciplinary processes, referral to Disclosure and Barring Service (DBS) and/or appropriate professional bodies such as Nursing and Midwifery Council (NMC), or the Health and Care Professions Council (HCPC)
- consider a referral to the Safeguarding Adults Board, SAR or other actions across the safeguarding partnership
- case closure – (see below)

These meetings can be managed in a number of ways but the key is to ensure the correct people are involved. Sometimes it will be appropriate to meet first without the provider to ensure that all information is shared and the provider is not overwhelmed by this. A smaller group would then meet immediately afterwards to talk the provider through the concerns. It is essential that commissioners are involved in both these meetings. The plan would be carried from one meeting to the other. The aim would be for subsequent meetings to be of all parties.

It is essential that all participants are aware that meetings are confidential and will be minuted. Minutes and communications about Organisational Safeguarding Enquiries must be carried out securely, in line with information governance policies.

Organisational Safeguarding Closure

It is important that the decision to end the Organisational Safeguarding Enquiry is agreed by the whole meeting membership. It is therefore essential that key agencies remain involved in the safeguarding process. The multi-agency meeting will need to be satisfied that:

- all required safeguarding actions have been undertaken;
- there is evidenced reduction in risk
- victims/involved adults have received feedback
- any necessary notifications to regulatory bodies e.g. Disclosure and Barring Agency, Nursing and Midwifery Council, have been undertaken
- any remaining concerns can and will be managed through contract monitoring, care management processes etc.
- lessons learned have been identified and taken forward

All placing commissioning bodies and CQC should be notified of the safeguarding closure once confirmed.

The Head of Safeguarding should be notified of safeguarding closure.

Publicity and Media

Public and media interest may arise in safeguarding cases. Specifically in all organisational safeguarding situations it is essential that **under no circumstances should media comment be made without reference to the Council's Communications Unit.**

Where media interest is likely the Head of Safeguarding will proactively manage this with the Communications Unit, coordinating with other organisation's media function where necessary.

Appendix 1

Early Indicators of Concern in Care Services Checklist

It is important to note that this is not a definitive checklist. Other indicators may be identified that do not appear on this list. Equally abuse can happen when indicators of concern are not present.

These indicators have been written to apply to all services that work with adults who have care and support needs. Not every indicator will 'fit' every type of service and practitioners should consider the nature of the service when referring to this list.

1. Concerns about management and leadership

The manager of the service

• The manager leaves suddenly and unexpectedly
• The service has not had a registered manager in post over an extended period
• Arrangements to cover the service while the manager is away are not working well
• The manager is new and doesn't appear to understand what the service is set up to do
• A responsible manager is not apparent or available within the service and has little involvement with the adults
• The manager leaves staff to get on with things with little active guidance or modelling of good practice
• The manager is very controlling

Management Culture

• The service is not being managed in a planned way, but reacts to problems and crises
• The service does not respond appropriately when a serious incident has taken place
• The service fails to learn from previous incidents and does not appear to be taking steps to reduce the risk of a similar incident happening again
• Policies, procedures and practice guidance are absent or inadequate

The management team

• Senior staff have been in post a long time and have a high level of authority and entrenched views
• There is a high turnover of managers
• The service is experiencing difficulty in recruiting and appointing managers
• There is a lack of leadership by managers, for example managers do not make decisions and set priorities

• Managers appear unaware of serious problems in the service
• Managers do not appear to be attending to risk assessments or are not ensuring that risk assessments have been carried out properly
• Managers do not appear to have ensured that staff have information about individual adults' needs and potential risks to adults
• Managers appear unable to ensure that actions agreed at reviews and other meetings are followed through
• There is a lack of effective monitoring by senior staff – including support to night staff and checks on them
• The managers know what outcomes should be delivered for adults, but appear unable to organise the service to deliver these outcomes, i.e. they appear unable to 'make it happen'

Staffing
• Staff who raise issues are not listened to
• Staff are not being deployed effectively to meet the needs of adults
• There is a high turnover of staff
• Staff are working long hours
• Staff are working when they are ill
• There is poor staff morale
• Recruitment processes are inadequate
• The service employs high numbers of family/friends
• There is a failure to identify concerning behaviour by staff e.g. stressed staff behaving unusually, growth of cliques, failure to work to best practice, cutting corners
• The managers have low expectations of the staff
• Staff have poor pay and conditions of employment

2. Concerns about staff skills, knowledge and practice

Supervision and Training
• Staff receive little/no supervision, appraisals or opportunities for development
• Induction processes are inadequate
• Poor quality or no training is provided
• Staff appear to lack the information, knowledge and skills needed to support the people the service is set up to support
• Staff lack training in how to use equipment

Recording
• Record keeping by staff is poor
• Staff do not appear to see keeping records as important
• Risk assessments are not completed or are of poor quality. For example, they lack details or do not identify significant risks
• Incident reports are not being completed
• Records are value laden and judgemental

Mental capacity and DOLS
• There is non-adherence to the principles of the Mental Capacity Act
• There is a lack of understanding of DOLS/LPS
• DOLS/LPS referrals are not being made resulting in people being unlawfully deprived of their liberty

Interactions with Adults
• Staff appear challenged by some adults' behaviours and do not manage these in a safe, professional or dignified way
• Staff perceive the behaviours of adults as a problem – and blame the adults
• Staff blame adults' medical condition for all their difficulties, needs and behaviours; other explanations do not appear to be considered
• Adults are punished for behaviours seen to be inappropriate
• Staff treat adults roughly or forcefully
• Staff ignore adults
• Staff are impatient with adults
• Staff talk to adults in ways which are derogatory/not complimentary
• Staff shout or swear at adults
• Staff do not alter their communication style to meet individual needs. For example, they speak to people as if they are children, they 'jolly people along'
• Staff use negative or judgemental language when talking about adults
• Staff do not see adults as individuals and do not appear aware of their life history
• Staff do not ensure privacy for people when providing personal care
• Staff tell adults to use their incontinence pads rather than assist them to use the toilet

Culture
• There is a particular group of staff who strongly influence how things happen in the home
• Staff informally complain about the managers to visiting professionals
• Staff appear to lack interest and commitment
• Staff appear to lack concern for the adults
• Staff appear unable to relate to a particular adult
• Staff are complacent about the quality of care they provide and appear defensive when challenged

3. Concerns about adults' behaviours and wellbeing

Individual adults
• Show signs of injury due to lack of care or attention (e.g. through not using wheelchairs carefully or properly, or the development of pressure injuries due to lack of or inappropriate use of pressure relieving equipment)
• Appear frightened or show signs of fear
• Behaviours or appearances have changed, for example they have become unkempt or are no longer taking pride or interest in their appearance
• Moods or psychological presentation have changed

• Behaviour is different with certain members of staff/when certain members of staff are away
• Engage in inappropriate sexualised behaviours
• Do not progress as would be expected
• Experience sensory deprivation – e.g. going without spectacles or hearing aids
• Experience restricted mobility by being denied access to mobility aids
• Experience restricted access to toilet/bathing facilities
• Lack personal clothing and/or possessions

General Service concerns
• The overall atmosphere is flat, gloomy or miserable
• There is a high number of low level incidents such as medication errors or falls
• There is a high number of incidents between adults
• There are a high number of upheld complaints about the service
• There is evidence of inappropriate restraint methods or misused restraint, including the inappropriate use of medication
• The care regime exhibits lack of choice, flexibility and control
• The care regime appears impersonal and lacks respect for individual's privacy and dignity
• The service does not adhere to local/national guidance, for example in a pandemic

4. Concerns about the service resisting the involvement of external people and isolating individuals

Information sharing
• The service has few visitors/minimal outside contacts
• The service does not report safeguarding concerns
• The service does not communicate with or report concerns to external practitioners and agencies
• The service does not liaise with families and ignores their offers of help and support
• Managers and/or staff do not respond to advice or guidance from practitioners and families who visit the service
• Managers do not appear to provide staff with information about adults from meetings with external people, for example reviews
• Staff or managers appear defensive or hostile and concerned to avoid blame when questions or problems are raised by external practitioners or families
• Managers or staff give inconsistent responses or accounts of situations

Staff
• Staff work alone on a one to one basis with adults
• Staff work in silos e.g. night staff who never work days
• Staff are hostile towards or ignore practitioners and families who visit the service

Adults
• There are adults who have little contact with people from outside the service
• There are adults who are not receiving active monitoring or reviews (e.g. people who are self-funding)
• Adults are kept isolated in their rooms and are unable to move to other parts of the building or outside independently ('enforced isolation')
• Adults have restricted access to visitors or phone calls
• Adults have restricted access to health or social care services

5. Concerns about the way services are planned and delivered

The nature of the service
• The service does not have a clear philosophy/purpose
• The service does not appear able to deliver the service or support it is commissioned to provide. For example it is unable to deliver effective support to people with distressed or aggressive behaviour
• Decisions about what service is commissioned for an individual are influenced by a lack of suitable alternatives
• The service is accepting adults whose needs and/or behaviours are different to those of the adults previously or usually accepted
• The service is accepting adults whose needs they appear unable to meet
• Adults' needs as identified in assessments, care plans or risk assessments are not being met. For example adults are not being supported to attend specific activities or provided with specific support to enable them to remain safe

Person-centred care
• Staff are task focussed and not providing person-centred care
• Adults are treated en-masse
• The service follows strict, regimented routines – for mealtimes, bedtimes, etc
• Adults lack choice about food and drink, dress, possessions, activities and where they want to spend their time
• Members of staff are controlling of adults
• There are misunderstandings about confidentiality

Resources
• There is a failure to provide and/or maintain correct moving and handling and other equipment such as pressure relieving mattresses
• The service is under resourced – whether staff, equipment or provisions
• There appear to be insufficient staff to support adults appropriately

Audits
• There is a lack of audits of practice and process
• There is a failure to follow up on issues raised by audits
• There is a failure to monitor the use of call bells including checking they have not been disabled – especially at night

6. Concerns about the quality of basic care and the environment

Person-centred care

• There is a lack of privacy, dignity and respect for people as individuals
• There is a lack of provision for dress, diet or religious observance in accordance with adults' individual beliefs or cultural backgrounds
• Adults do not have as much money as would be expected
• Adults lack basic things such as clothes, toiletries
• Support for adults to maintain personal hygiene and cleanliness is poor and they appear unkempt
• Adults are not getting the support they need with eating and drinking, or are not getting enough to eat or drink
• There is poor or inadequate support for adults who have health problems or who need medical attention
• Staff are not checking that people are safe and well
• There are a lack of activities or social opportunities for adults
• There is a lack of care for adults' property and clothing

Resources

• There appear to be insufficient staff to meet adults' needs
• The service does not have the equipment needed to support adults and keep them safe
• Equipment or furniture is broken
• Equipment is not being used or is not being used safely and correctly

Environment

• The service is not providing a safe environment
• The environment is dirty and shows signs of poor hygiene
• The quality of the environment has deteriorated noticeably