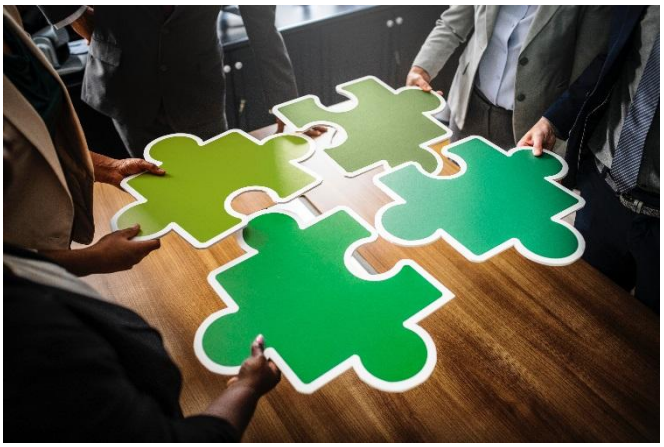
South Gloucestershire Safeguarding Adults Board



Organisational Abuse

Procedures

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Contents

Appendices:

Introduction

This guidance outlines how to identify and respond to concerns about organisational abuse affecting adults with care and support needs. Its primary focus is to ensure the safety and wellbeing of those individuals. It should be used alongside the South Gloucestershire Multi-agency Safeguarding Policy & Procedures. The aim is to strengthen staff understanding of organisational abuse, recognise key signs and indicators, and clarify responsibilities for taking timely and appropriate action when concerns arise.

Definition

Safeguarding protects an adult's right to live safely, free from abuse and neglect. It requires individuals and organisations to work together to prevent, reduce and respond to risks of harm.

According to the Care Act 2014 statutory guidance (14.9), safeguarding does **not** replace:

- Providers' responsibilities to deliver safe, high-quality care and support
- Commissioners' duties to assure themselves of the safety and effectiveness of the services they commission
- The Care Quality Commission's role in ensuring compliance with fundamental standards and taking enforcement action where required
- The core responsibilities of the police to prevent and detect crime and protect life and property

Local authorities should adopt a broad and flexible view of what may constitute abuse or neglect, recognising that it can take many forms and must always be considered in the context of each individual's circumstances.

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 incidents

arising from an organisation's culture, practices, or procedures, including the behaviours and attitudes of its managers and staff.
Organisational Safeguarding applies to all services in South Gloucestershire that 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 but not limited to, care homes, domiciliary care services, supported living services, day care services, services for asylum seekers and hospitals.

Early Indicators of Organisational Abuse

Research and practitioner experience have identified several early warning indicators of organisational abuse. Awareness of these signs enables practitioners to recognise concerns, validate their observations, and take timely action to safeguard individuals. While Appendix 1 outlines common indicators, the list is not exhaustive, and other relevant signs may also emerge.

These indicators fall within six overarching themes, each highlighting aspects of service design and delivery that may increase the risk of abuse or harm.

The 6 main areas to think about are:

1. Concerns About Management and Leadership
Consider whether managerial actions, omissions, or aspects of the organisational culture may place people at risk of abuse or neglect.

2. Concerns About Staff Skills, Knowledge and Practice
Assess the competence and practice of all staff—including care, clinical, managerial and ancillary roles—and identify any behaviours or gaps in skills that may increase the risk of harm.

3. Concerns About People's Behaviours and Wellbeing
Observe whether individuals using the service show signs or behaviours that may indicate distress, abuse or neglect, and consider any concerns raised by them or by their families or representatives.

4. Concerns About Resistance to External Involvement and Isolation
Identify whether the service limits external scrutiny, restricts contact with others, or otherwise isolates the people it supports, resulting in reduced transparency or oversight.

5. Concerns About How Services Are Planned and Delivered
Determine whether the care provided aligns with assessed needs and agreed plans, whether group compatibility is appropriate, and whether the service is clear and realistic about its capabilities.

6. Concerns About the Quality of Basic Care and the Environment
Evaluate whether people's fundamental needs are met and whether the physical environment supports safety, dignity and wellbeing.

It is important to note:

- This guide supports practitioners to record concerns, reflect on observations, seek advice, and take appropriate action.
- Concerns within any number of the six themes may indicate issues at a service level; all themes do not need to be present.
- Patterns of concern do not in themselves confirm abuse, and abuse may occur even when indicators are not evident.
- This guide does not replace listening directly to people using services; rather, it emphasises the importance of doing so before and after concerns are raised.

Equality, Diversity and Inclusion

Organisations must demonstrate a clear commitment to upholding human rights. Alongside the domains outlined above, explicit consideration should be given to Equality, Diversity and Inclusion, ensuring that the needs of individuals with protected characteristics are fully met. Both staff and people with care and support needs must be treated fairly and without discrimination.

Whistleblowing

A whistleblowing referral can be an important source of information and may highlight broader concerns about a service. Whistleblowing differs from a complaint in that it is usually raised by a current or former employee. They may or may not have attempted to address the issue internally, and in some cases may feel unable to do so. If the concern relates to the safety of an individual, it should first be managed through individual safeguarding procedures. Where concerns indicate wider systemic issues, they should be considered through organisational safeguarding processes.

Information provided by whistleblowers should be recorded carefully, regardless of the individual's motives. A difficult relationship with an employer does not invalidate the information, which should be assessed and weighed alongside other available evidence.

Each organisation will have its own Whistleblowing Policy, which individuals should refer to where possible. However, the priority is to ensure concerns are reported. If there is any uncertainty, whistleblowers should contact the First Contact Team on 01454 868007 for advice.

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

Decision making for carrying out Organisational Abuse Enquiries

The Adult Strategic Safeguarding Team determines whether an Organisational Safeguarding Enquiry is required and leads the process. The team works proactively with care providers—conducting early visits, offering guidance, and signposting—to reduce the likelihood of concerns escalating to a formal enquiry.

Professional judgement is essential in determining when poor practice escalates into an adult safeguarding concern. The following four questions support decision-making when considering an organisational abuse enquiry:

1. **Type of concern:** Do the issues align with indicators listed in the Early Indicators of Concern Checklist?
2. **Nature of concern:** Is the behaviour widespread, embedded in the service culture, or accepted or enabled by management?
3. **Severity and impact:** How long have the concerns been present, what impact have they had on individuals, and is there a risk of recurrence or escalation?
4. **Pattern and frequency:** Are similar concerns being reported repeatedly or by multiple agencies?

A positive response to all four questions is not required. A single serious incident may be sufficient to trigger consideration for an organisational safeguarding enquiry.

The decision making process will include a review of all the concerns and current sources of evidence, including feedback from people who use the service and professionals. It will consider:

- 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 commissioning team – 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, mental health services, etc. It may also be relevant to consider attendances at emergency departments
- practitioner views – any feedback arising from reviews or individual safeguarding enquiries

The decision-making process will assess the issues identified under the six key themes and provide a recommendation for next steps. The Safeguarding Adults Manager will determine whether an Organisational Safeguarding Enquiry should be initiated.

If the decision is made not to proceed with an organisational safeguarding enquiry then the Safeguarding Adults Manager will record how the issues arising are to be followed up e.g. by a safeguarding or quality assurance visit to the provider, through individual enquiries or by a visit from another service such as the Care Quality Commission.

The decision-making process and rationale for actions will be shared with the management of the service under consideration.

Organisational Safeguarding Enquiries

Partnership Working: Key Points

Responding to organisational abuse requires coordinated multi-agency involvement. Early engagement in the safeguarding process ensures that enquiries are informed and effective, with all parties clear on their roles, responsibilities, and duty to cooperate.

South Gloucestershire Council, as the host authority, leads and coordinates organisational safeguarding enquiries. Strong multi-agency collaboration, effective information sharing, and joint decision-making are essential to achieving safe and positive outcomes for people using the service.

Who Leads?

The Safeguarding Adults Manager or Senior Practitioner will ordinarily coordinate organisational safeguarding enquiries and chair related meetings. In exceptional circumstances—such as when risks are high or coordination is not feasible—the Service Director for Adult Social Care will be consulted to agree an alternative chair and coordinator. Each participating organisation will nominate a lead representative. Where the service supports individuals under 18, the enquiry will be led by the Children's Strategic Safeguarding Manager.

The relationship between social care activity and any police or criminal investigation must follow the South Gloucestershire SAB Policy and Procedures. For each enquiry, agencies must balance the need to preserve evidence with ensuring the safety and protection of adults within the service.

Effective partnership working is essential. The Council, Police, Integrated Care Board and Care Quality Commission each have specific roles that contribute to a robust safeguarding response. Multi-agency collaboration must be coordinated, transparent and balanced, avoiding disproportionate influence by any single organisation.

Service providers are expected to engage cooperatively. Depending on the seriousness and nature of the concerns, the local authority will determine whether the provider can undertake elements of the enquiry. Understanding the provider's internal processes—such as disciplinary procedures—is crucial, particularly where these processes may have contributed to or enabled abusive practice. Providers must acknowledge responsibility for both the abuse and its impact.

Where providers are asked to undertake enquiries, expectations, scope, timescales and reporting requirements must be clearly defined. Any failure to meet these requirements should prompt escalation to ensure concerns are appropriately managed.

Organisational safeguarding enquiries often involve multiple individuals and may require several individual safeguarding enquiries. While the Local Authority holds lead responsibility under the Care Act 2014, it may delegate specific enquiries to other appropriate agencies. The Chair will coordinate the overall process to ensure all relevant agencies are fully involved.

Organisational Safeguarding Meetings

When the seriousness of safeguarding concerns indicates that an organisational safeguarding enquiry is required, the local authority will convene a multi-agency meeting. Agencies that will be invited to attend will vary according to the specific circumstances of the enquiry but could include the following key partners:

- Police
- Care Quality Commission
- Local Authority Commissioning & Contracts
- Health – ICB, CHC, primary care
- Other Local Authorities who use the service
- Non-statutory/Voluntary sector organisations

All organisations working with the care service subject to the enquiry should be included in the enquiry process and will be equal partners in the process.

(See ADASS guidance on ADASS Out-of-Area Safeguarding Adults Arrangements Protocol - ADASS for further details).

An initial meeting should be called as soon as possible. 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. The initial 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.

Follow-up meetings may be held to ensure actions are completed and plans updated as necessary. These meetings will:

- Oversee implementation of the enquiry.
- Review partner reports.
- Evaluate the enquiry and the evidence gathered.
- Determine whether abuse or neglect occurred at an individual or organisational level.
- Consider the circumstances and potential needs of any perpetrator(s).
- Agree a safeguarding plan with short- and medium-term actions.
- Set timescales for reviewing the safeguarding plan.
- Identify triggers for re-evaluation of the situation.
- Agree an action plan for the service provider.
- Monitor and review the provider's action plan.
- Conduct a debrief and identify learning and wider implications.
- Receive updates from the provider on follow-up actions (e.g., disciplinary processes, referrals to professional bodies).
- Consider referral to the Safeguarding Adults Board, a SAR, or other partnership processes.
- Confirm arrangements for case closure

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

The decision to conclude the Organisational Safeguarding Enquiry must be agreed by all members of the multi-agency meeting. Ongoing involvement from key agencies is therefore essential. Closure can only be considered when the meeting is satisfied that:

- All required safeguarding actions have been completed.
- There is clear evidence that risks have reduced.
- Feedback has been provided to the adults affected.
- Any required notifications to regulatory bodies (e.g., Disclosure and Barring Service, Nursing and Midwifery Council) have been made.
- Any necessary referrals to the Positions of Trust Lead (PIPOT) or the Local Authority Designated Officer (LADO) have been completed.
- Any remaining issues can be effectively managed through contract monitoring, care management, or other operational processes.
- Lessons learned have been identified and embedded.

Where there is disagreement about the process of the organisational safeguarding enquiry or its closure, then these should be resolved using the Resolution of Professional Differences Policy

Publicity and Media

Public and media interest may arise in safeguarding cases, including on social media. 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 Service Director - Adult Social Care will proactively manage this with the Communications Unit, coordinating with other organisation's media function where necessary.

Information Sharing

Beyond the agencies referred to above, information in relation to the Organisational Safeguarding enquiry should not be shared without the explicit agreement of the chair/enquiry lead. However, whilst remaining sensitive to reputational damage and market sustainability, providers should be aware, that where the need is identified, they may be asked to share information in relation to the organisational enquiry with their staff team and/or users of their service. This often relates to the need to provide assurances and share progress, in order to alleviate concerns or recognise efforts of those working hard to make the necessary improvements. Information that could lead to the identification of specific individuals should never be shared.

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 people receiving support
• 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 including the organisations whistle-blowing policy 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 people's needs and potential risks to them
• 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 people, but appear unable to organise the service to deliver these, 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 people who use the service
• 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 little/no training is provided
- Training is not compliant with current legislation/best practice
- 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

• Care plans are not individual to the person they relate to and do not promote their needs, wishes or preferences
• 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
• People are not supported to make choices/empowered to make decisions about their lives
• There is a lack of understanding of DOLS or the proposed legislative changes to the Liberty Protection Safeguards (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 people's behaviours and do not manage these in a safe, professional or dignified way
• Staff perceive the behaviours of people as a problem – and blame them
• Staff blame people's medical condition for all their difficulties, needs and behaviours; other explanations do not appear to be considered
• People are punished for behaviours seen to be inappropriate
• Staff treat people roughly or forcefully
• Staff ignore people
• Staff are impatient with people
• Staff talk to people in ways which are derogatory/not complimentary
• Staff shout or swear at people
• 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 people
• Staff do not see people as individuals and do not appear aware of their life history
• Staff do not ensure privacy for people when providing personal care
• Staff tell people 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 people using the service
• Staff appear unable to relate to a particular person
• Staff are complacent about the quality of care they provide and appear defensive when challenged

3. Concerns about peoples' behaviours and wellbeing

Individuals

• 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 people who use the service
• 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 people 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
- The service does not support people to attend health appointments

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

People who use the service

• There are people who have little contact with others from outside the service
• There are people who are not receiving active monitoring or reviews (e.g. people who are self-funding)
• People are kept isolated in their rooms and are unable to move to other parts of the building or outside independently ('enforced isolation')
• People have little or restricted access to meaningful occupation or activity inside or outside of the environment
• People have restricted access to visitors or phone calls
• People 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 people whose needs and/or behaviours are different to those of people previously or usually accepted
• The service is accepting people whose needs they appear unable to meet
• Peoples' needs as identified in assessments, care plans or risk assessments are not being met. For example they 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
• People are treated en-masse
• The service follows strict, regimented routines – for mealtimes, bedtimes, etc
• People lack choice about food and drink, dress, possessions, activities and where they want to spend their time
• Members of staff are controlling of people who use the service

• 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 appears to be insufficient staff to support people 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 people's individual beliefs or cultural backgrounds
- People do not have as much money as would be expected
- People lack basic things such as clothes, toiletries
- Support for people to maintain personal hygiene and cleanliness is poor and they appear unkempt
- People 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 people 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
- There is a lack of care for people's property and clothing
- There is high number of 'low level' incidents such as falls and medication errors

Resources
• There appear to be insufficient staff to meet people's needs
• The service does not have the equipment needed to support people 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 not personalised to the people who live there – lacking photographs and personal items
• People are not supported to have a say in how the environment is decorated/furnished
• The environment is dirty and shows signs of poor hygiene
• The quality of the environment has deteriorated noticeably