Safeguarding Adults Best Practice Matrix

- The matrix below contains examples of concerns (not an exhaustive list) with an indication of which action level they may fit into. There will be cases that do not fit easily into a specific level and advice should be sought from your organisation's Adult Safeguarding Lead.
- If an adult with care and support needs either died or experienced serious harm as a result of abuse or neglect and there is reasonable cause for concern that agencies could have worked together more effectively to protect the adult, a Safeguarding Adult Review may need to be considered and you should discuss this with your safeguarding lead.
- Every person has the right to have their concerns reported through the correct procedures; this may include a safeguarding referral. If a person does not have capacity to make this decision you must consider whether a safeguarding referral needs to be made in their best interests. Where harm has been, or may have been, caused to a patient by an act or omission of the organisation or its staff, the patient must be informed. In addition all concerns must be reported in line with your organisation's internal escalation processes.

Type of Abuse	NOT SAFEGUARDING NORMAL CARE MANAGEMENT ISSUES	NOT SAFEGUARDING SERVICE IMPROVEMENT / QUALITY ISSUES	SAFEGUARDING REFERRAL MAY BE REQUIRED CONTACT YOUR SAFEGUARDING LEAD FOR DISCUSSION	SAFEGUARDING REFERRAL REFERRAL TO POLICE SHOULD BE CONSIDERED	SAFEGUARDING REFERRAL REFERRAL TO POLICE REQUIRED
PHYSICAL (FALLS)	• Isolated incident (risk assessment reviewed, associated care plan in place. • Risk assessment and associated care plan in place but is not being followed. There is no harm to the person.	• One person experiencing recurring falls whilst in a care setting or receiving care services (risk assessment reviewed, care plan reviewed, appropriate referral made to relevant health professional) and no harm has occurred • One-off fall of more than one person within the same care setting, no harm has occurred	• Fall where serious harm occurs whilst in receipt of care (e.g. fractured long bone). Consider referral as a serious incident if this meets the framework criteria.	• Fall causing serious harm to person, leading to the need for medical intervention where there has been previous concerns identified • Previous concerns identified but not addressed • Insufficient prevention measures in place such as training, supervision & auditing • Numerous falls affecting more than one person from the same care setting or care provider requiring medical treatment.	• One fall causing catastrophic harm to one person possible-hospitalisation / irreparable damage / death where there has been previous concerns identified • Insufficient prevention measures for care providers in place such as training, supervision & auditing.
PHYSICAL ABUSE	• Staff error causing no/little harm, e.g. superficial skin friction mark • Minor events that still meet criteria for 'incident reporting	• Isolated incident involving service user on service user • Inexplicable very light marking found on one occasion	• Inexplicable marking or lesions, burns, cuts or grip marks on a number of occasions • Accumulation of minor injuries on one person or within one working area e.g. ward, care home	• Inappropriate restraint • Inexplicable fractures/injuries to any part of the body that may be at various stages in the healing process	• Assault • Grievous bodily harm/assault leading to significant harm, irreversible damage or death
PHYSICAL (PRESSURE ULCERS)	• Pressure damage with no evidence of neglect OR failure to provide adequate care or pressure relieving equipment. • Person has capacity and makes an informed decision to decline treatment. A pressure ulcer develops.	• Pressure damage that meets the threshold of a serious incident should be reported. As part of the SI process, the following questions must be considered: 1. Has there been rapid onset and /or deterioration of skin integrity? 2. Has there been a recent change in medical condition e.g. skin or wound infection, other infection, pyrexia, anaemia, end of life care that could have contributed to a sudden deterioration of skin condition? 3. Have reasonable steps been taken to prevent skin damage? 4. Is the level of damage to the skin disproportionate to the person's risk status for skin damage? e.g. low risk of skin damage with extensive injury. 5. Is there evidence of poor practice/neglect?	• Person not risk assessed with regards to pressure ulcers risk and management and harm occurs • Failure to provide suitable pressure relieving equipment and harm occurs • Failure to follow the advice of clinical specialists and harm occurs • Pressure ulcers that have been investigated through the SI process and have found to be preventable AND the 5 questions outlined in box 2 have been considered. If this affects more than one person, Organisational Abuse should be considered	As box 3. If this affects more than one person, Organisational Abuse should be considered	• Person not risk assessed with regards to pressure ulcers risk and management leading to catastrophic harm/possible hospitalisation/ irreparable damage/death • Failure to provide suitable pressure relieving equipment / follow the advice of clinical specialists leading to catastrophic harm/ possible hospitalisation/irreparable damage/ death If this affects more than one person, Organisational Abuse should be considered
MEDICATION	• Adult does not receive prescribed medication (missed/wrong dose) on one occasion and no harm occurs • Minimal harm to one person but robust prevention measures in place such as training, supervision & auditing	• Recurring missed medication or administration errors in relation to one service user that cause no harm and no ongoing concerns • Prevention measures in place such as training, supervision and auditing	• One-off medication error to more than one person - no harm caused • Recurring missed medication or errors that affect more than one adult and/or result in harm • Medication error causing serious harm to person, leading to need for medical intervention • Previous concerns identified • Insufficient prevention measures in place such as training, supervision & auditing • Appearing to be over medicated	• Deliberate maladministration of medications • Covert administration without proper medical supervision	• Recurring errors, or an incident of deliberate maladministration, that results in ill-health or death. • Catastrophic harm to more than one person leading to hospitalisation/long term effects/ death
SEXUAL	Every person has the right to have their concerns reported through the correct procedures; this may include a safeguarding referral. If a person does not have capacity to make this decision you must consider whether a safeguarding referral needs to be made in their best interests.		• Isolated incident when an inappropriate sexualised remark is made to an adult and no or little distress is caused • Verbal sexualised teasing that causes offence	• One off or recurring sexualised touch or isolated/recurring masturbation without consent • Attempted penetration by any means (whether or not it occurs within a relationship) without consent	• Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user • Sex without consent/rape • Being made to look at pornographic material without consent