

# Safeguarding Adults at Risk of Harm Policy

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| <i>Lead Director:</i>                | <i>Nick Goldup – Director of Care Improvement</i>                 |
| <i>Lead Manager:</i>                 | <i>Tracey Thompson – Head of Regional Care Partnerships North</i> |

## Policy history

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| 3.0     | Tracey Thompson | 23/12/2016 | Updated   |
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| 8.0     | Tracey Thompson | 03/03/2023 | Two year policy review                                |

## Safeguarding Adults at Risk Policy

### Contents

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|  | Page      |
|--|-----------|
| <b>1. Policy Statement of Intent</b>   | <b>3</b>  |
| <b>2. Principles</b>   | <b>4</b>  |
| <b>3. Definitions</b>  | <b>5</b>  |
| <b>4. Legal and Policy Context</b>   | <b>8</b>  |
| <b>5. Reporting Safeguarding Concerns &amp; Making a Safeguarding Referral:<br/>Procedure for staff and volunteers in all Directorates</b> | <b>10</b> |
| <b>5.6 Out of Hours Emergency Response Service</b>   | <b>11</b> |
| <b>5.12 Referral Form – Safeguarding Adults</b>  | <b>13</b> |
| <b>5.15 Confidentiality</b>  | <b>13</b> |
| <b>5.21 General Data Protection Regulations (GDPR)</b>   | <b>14</b> |
| <b>5.22 Informing your Manager of the Referral</b>   | <b>15</b> |
| <b>5.25 Recording Guidance</b>   | <b>15</b> |
| <b>5.28 Allegations against Staff or Volunteers</b>  | <b>16</b> |
| <b>6. Supporting individuals at risk of suicide</b>  | <b>16</b> |
| <b>7. Supporting Policies</b>  | <b>17</b> |
| <b>8. Risk Assessment</b>  | <b>17</b> |
| <b>Appendix 1: Flowchart: Making a Safeguarding Referral – Adult at<br/>Risk of Harm</b>   | <b>18</b> |

## 1. Policy Statement of Intent

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The Motor Neurone Disease Association provides services to a wide range of people throughout England, Wales and Northern Ireland and we recognise that some people with whom we are in contact are adults at risk<sup>1</sup>.

The aim of this policy is to ensure that the Association acts appropriately when it becomes aware that an adult is at risk of harm. It also provides a framework which ensures that those involved in the care of adults at risk have the appropriate information and support to enable them to take the necessary steps to stop the neglect/abuse happening. Furthermore, the Association must have appropriate mechanisms in place to prevent neglect or abuse by any employee, supporter, volunteer, or associate of the organisation.

This policy is designed to inform and offer guidance to staff and volunteers in all Directorates across the MND Association, in the management of issues relating to protecting, safeguarding, and promoting the welfare of adults at risk. Whilst we are not a statutory social care organisation **all staff and volunteers, from whichever Directorate, have an obligation and responsibility to be aware of and report concerns related to protection, safeguarding and promotion of the welfare of adults at risk from harm.**

This policy will be reviewed and revised as and when it becomes necessary and at least every two years.

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<sup>1</sup> The term 'vulnerable adult' is no longer used and has been replaced by 'adults at risk of harm' usually shortened to 'adults at risk' in policies and procedures. Reference may also be given to an 'adult with a care and support need'. In NI, the terms 'adults at risk' and 'adults in need of protection' are commonly used

## 2. Principles

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**The MND Association's safeguarding arrangements are underpinned by the following key principles:**

- 2.1 Safeguarding is everyone's responsibility;** for those adults we work with/come into contact with to be safe, and for our services to be effective, each employee and volunteer must play their full part in safeguarding adults at risk of harm.
- 2.2** All staff and volunteers working with adults at risk must listen to what they say, take their views seriously; and work with them collaboratively when deciding how to support their needs, as appropriate.
- 2.3** Procedures are in place to ensure concerns of abuse or neglect are dealt with appropriately and that action is taken promptly.
- 2.4** Recruitment and selection policies and procedures for staff and volunteers will take account of the need to safeguard and protect adults at risk. This will include the introduction and adoption of Safer Recruitment tools and techniques.
- 2.5** Induction training for all new staff and volunteers will include safeguarding policies and procedures. Regular safeguarding training will be delivered at different levels, dependent on staff/volunteer's level of responsibility and their likely direct or indirect contact with adults at risk. All staff and volunteers will be required to complete MND Association specific E-learning module as part of their induction. Staff and volunteers will also have access to appropriate guidance and support when required and as appropriate.
- 2.6** All staff and volunteers will have access to an Association Designated Safeguarding Manager (DSM) and details of the appropriate local agencies to which safeguarding concerns can be reported. The DSM will be the relevant Head of Regional Care Partnerships (HoRCP) in the first instance or a member of the Care Directorate Leadership team (CLT)<sup>2</sup> where a HoRCP is unavailable.
- 2.7** The Director of Care Improvement is the Association's Safeguarding Lead and is responsible for maintaining a strategic overview of all safeguarding matters within the MND Association<sup>3</sup> – this is not the same role as Designated Safeguarding Manager.

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<sup>2</sup> CLT membership consists of Director of Care Improvement, Deputy Director of Care, Head of Regions (x 4), Head of Education & Information, Head of National Care

<sup>3</sup> The Director of Care Improvement chairs the Association's Safeguarding Board

A Safeguarding Board meets quarterly to advise the Executive on safeguarding matters, as they relate to the work undertaken at the MND Association.

- 2.8** The policy reflects the differences in health and social care structures and legislation for safeguarding adults at risk across England, Wales, and Northern Ireland. However, the Association adopts the same safeguarding principles across all three Nations.
- 2.9** All Staff who have direct contact with adults, children and/or families at risk of harm - online, by telephone or face to face should be encouraged to access additional training and information that may enhance their role and confidence in identifying safeguarding risks and concerns. This may be training provided by Local Safeguarding Boards and other suitable local external providers, *as appropriate*.
- 2.10** As part of the Association's managing and escalating safeguarding incidents, staff are required to complete a 'Safeguarding After Action Review' (AAR) process as appropriate. [Please refer to Appendix 15 for AAR template.](#)

**It is the responsibility of all managers in The MND Association to be conversant with this policy and its practice implications and to ensure that all staff and volunteers for whom they are responsible understand the policy, are aware of their responsibilities within it and are sufficiently trained and supported to deliver the procedures set down in this policy.**

### **3. Definitions**

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#### **3.1 Who is an adult at risk of harm?**

The original definition of a 'vulnerable adult' originated in the Department of Health guidance 'No Secrets' (2000), should now be replaced with the new definition from the Care Act (2014). This moves away from the terminology of 'vulnerable adults' towards 'adults at risk of harm' usually shortened to 'adults at risk'. There may also be reference to an 'adult with a care and support need'. The Care Act 2014 makes it clear that abuse of adults is linked to *circumstances* rather than the characteristics of people experiencing the harm.

An adult at risk is a person aged 18 years or over who is, or may be in need of, community care services by reason of mental health issues, learning or physical disability, sensory impairment, age or illness and is or may be unable to take care of him/herself, or unable to protect him/herself against harm or exploitation<sup>4</sup>

The **principles** surrounding safeguarding adults are the same across all Three Nations, regardless of different pieces of legislation. So:

- **The Care Act 2014 (England)** talks about: Protecting an adult's right to live in safety, free from abuse and neglect.
- **The Social Services and Well Being (Wales) Act 2016** talks about: Promoting the well-being of people who need care and support (this Act is for adults, children and carers) and that safeguarding adults is concerned with protecting those (adults at risk) from suffering abuse or neglect.
- **The Adult Safeguarding Policy (Northern Ireland) 2015**, talks about; Improving safeguarding outcomes for all adults who are at risk of harm through abuse, exploitation, or neglect.

### 3.2 What does mental capacity mean?

Mental capacity refers to a person's ability to make decisions for themselves or about their own life. Some people have difficulties in making such decisions. This is called 'lacking capacity'. Under the Mental Capacity Act 2005 there are laws governing who can make decisions on someone else's behalf which help safeguard adults at risk of harm.

### 3.3 What do we mean by abuse?

Abuse is a violation of a person's human rights or dignity by any other person or persons<sup>5</sup>. There are many kinds of abuse, which can be carried out deliberately or unknowingly and it may be a single or repeated act. Abuse includes physical, sexual, psychological, financial, or material, neglect or acts of omission (including self-neglect), discriminatory, institutional abuse, human and civil rights.

This is not an exhaustive list but provides a guide to the most regular forms of abuse. [Please refer to Appendix 14 \(Glossary – Adults\) for more detail.](#)

**3.4** Any of these forms of abuse can be either deliberate or the result of ignorance or lack of training, knowledge or understanding. Often if a person is being abused in one way they are also being abused in other ways.

### 3.5 Who may be an abuser?

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<sup>4</sup> Care Act (2014)

<sup>5</sup> Department of Health – No Secrets Guidance (2000)

The person who is responsible for the abuse may be a stranger but is often well known to the person being abused and could be:

- A relative/family member.
- Professional/staff member.
- Paid care worker.
- Volunteer.
- Other service user.
- Neighbour.
- Friend or associate.
- Children and young people can be abusers<sup>6</sup>

### 3.6 What are the signs?

Some of the following signs might be indicators of abuse or neglect:

- Multiple bruising or finger-marks.
- Injuries the person cannot give a good reason for.
- Deterioration of health for no apparent reason.
- Loss of weight.
- Inappropriate or inadequate clothing.
- Withdrawal or mood changes.
- A carer who is unwilling to allow access to the person.
- An individual who is unwilling to be alone with a particular carer.
- An unexplained shortage of money.

With respect to the **Association's online Forums**, online moderators may also be alerted by the following signs:

- Posting of inappropriate photos, images, or videos.
- Suicide notes or good-bye letters.
- Discussion of intentions to undertake risky activities, e.g. self-harm, or injury.
- Discussion of illegal activities, e.g. substance misuse.
- Sharing of personal information or pressurising others to share personal information, e.g. email addresses, phone numbers, instant-messaging.
- Change in the tone of messages.
- Direct reference to issues of a safeguarding nature, e.g. disclosure of abuse.

### 3.7 What is meant by the term 'Appropriate Agency'?

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<sup>6</sup> This includes any abusive behaviour including sexually abusive behaviour, committed by a child or young person towards any other person, whether child or adult.

These agencies are responsible for the investigation and coordination of all incidents of suspected abuse. This would fall within the jurisdiction of the agency closest to where the adult at risk is residing.

Where there is an indication that a criminal offence has been committed the appropriate agency is **ALWAYS** the police.

### 3.8 Designated Safeguarding Manager (DSM)

This is the manager designated within the Association to whom any safeguarding concerns should be escalated/reported.

Staff and volunteers should report any safeguarding concerns to their immediate line manager in the first instance. The line manager will report those concerns, in turn, to the DSM who will be the relevant Head of Regional Care Partnerships (HoRCP) for the geographical area in which the concern has been raised. If a HoRCP is unavailable, staff can speak to a member of the Care Directorate Leadership team. If concerns are raised outside of office hours, staff and volunteers should contact the manager on call

## 4. Legal and Policy Context

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There are a number of key pieces of legislation which set out the framework for all agencies working with adults at risk of harm. In summary these are:

- The Care Act 2014 (updated March 2016).
- Mental Capacity Act 2005.
- Government Statement of Policy on Adult Safeguarding (HM Government 2013).
- Safeguarding – roles and responsibilities in health and social care services (Department of Health, Local Government Association, ADASS, NHS Confederation, Association of Chief Police Officers 2013).
- Information Sharing Guidance (Department of Health).
- Commissioning for Better Outcomes (Department of Health, Local Government Association, ADASS, Think Local, Act Personal).
- Prevention in Safeguarding (Social Care Institute of Excellence, 2011).
- Making Safeguarding Personal – a toolkit for responses (Local Government Association, 2015).
- Gaining access to an adult suspected to be at risk of abuse or neglect – a guide for social workers and managers in England (SCIE, 2014).

- Adult Safeguarding Policy (Northern Ireland) (2015). Replaces Part 1 of 'Safeguarding Vulnerable Adults: Reg Adult Protection Policy and Guidance' September 2006.
- Social Services and well-being (Wales) Act 2016. (builds on the policy set out in *Sustainable Social Services for Wales: A Framework for Action*. Covers adults, children, and carers).
- Regulation and Inspection of Social Care (Wales) Act 2016.
- General Data Protection Regulations (May 2018).

Please refer to [Appendix 2 \(Legal & Policy Context\)](#)

## 5. Reporting Safeguarding Concerns and Making a Safeguarding Referral: Procedure for Staff and Volunteers in all Directorates

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Please refer to flowchart diagram at the end of this policy document – ‘Making a Safeguarding Referral for Adults at Risk of Harm’ – **Appendix 1**

The following procedures should be followed if you need to report a safeguarding concern or make a safeguarding referral:

**5.1 Your first priority should always be to ensure the safety and protection of an adult at risk.** To this end, if any person in the MND Association reasonably suspects or is told that an adult at risk is being, has been, or is likely to be abused they must take immediate action as set out in this policy and pass on their concerns to their immediate line manager.

**5.2** It is important to emphasise to anyone seeking assistance from the MND Association that we are **NOT** an agency with statutory powers to investigate allegations of abuse or neglect. Neither can we remove adults at risk from abusive situations. **But you do need to stress that you will have to share your concerns with a manager and possibly make a referral to a statutory agency, as we have a responsibility to pass on such information where there is an adult at risk, suffering or likely to suffer significant harm.** These statutory agencies are:

- the Police and/or the Local Authority Adult Social Care in England and Wales.
- the Health and Social Care Trust ‘Adult Protection Gateway Service’ in the relevant local area (HSCTs) and/or the Police Service Northern Ireland (PSNI) In Northern Ireland.

If a referral needs to be made urgently outside of normal office hours, the appropriate agency is:

- Adult Social Care Emergency Duty Team (EDT) in England and Wales.
- Regional Emergency Social Work Service (REWS) in Northern Ireland.

**If the person disclosing information to you is at risk of immediate physical harm or danger, ask them to call 999 and ask for the police, or alternatively make the call yourself. Contact Adult Social Care Services at the same time, to ensure that the safeguarding element is reported and followed up. A note must be placed on MrC under ‘Safeguarding Notes’**

**5.3 If an adult discloses a safeguarding concern** staff and volunteers should:

- Listen and acknowledge what is being said.
- Be reassuring and calm.
- Be aware that the person's ability to recount their concern or allegation will depend on age, culture, language and communication skills and disability.
- Not promise full confidentiality.
- Ask their consent to take up their concerns.
- Explain what you'll do next.
- Try to encourage and support them to share their information.
- Don't talk to the alleged abuser – confronting the abuser could make the situation much worse for the individual making the allegations, e.g. in situations where there is domestic violence.
- Don't delay in reporting the abuse – the sooner the abuse is reported after disclosure the better. Details will be fresh in your mind and action can be taken quickly.
- **Consult with your line manager, who in turn will discuss with the Association's Designated Safeguarding Manager (DSM).**

**5.4 If a concern or allegation is made about a staff member or volunteer within the Association:** do not inform the person in question as this might prejudice any police investigations. Contact your line manager immediately, who in turn will contact the Designated Safeguarding Manager and the Head of HR. If it is outside of office hours, contact the manager on call ([see section 5.6 below](#)).

**5.5 If the concerns or allegations are raised by a third party, e.g. a member of the public or another professional:** the staff member/volunteer receiving the allegation must make notes of the information and contact their line manager who in turn will contact the Designated Safeguarding Manager, who must consult with them immediately about what action to take.

**5.6 Out-of-Hours Emergency Response Service**

1. An out-of-hours Emergency Response Service will be provided by the MND Association Care Directorate for the Safeguarding of adults and children/young people (Note: this is an internal Association resource and not a statutory service)

2. The out-of-hours service will operate at the following times:

**Monday-Friday 5:00 p.m. - 11:00 p.m.**  
**Weekends & Bank Holidays 10:00 a.m. - 10:30 p.m.**

3. Outside of office hours staff and volunteers should telephone:

**03453 751855** to speak to the Association's Designated Safeguarding Manager.

4. Please leave a voicemail if initially no-one picks up - the Designated Manager will respond to the initial telephone call **within 2 hours** by telephoning back the staff member or volunteer on the number that they have given.
  5. The Designated Manager will provide advice on the situation and support the staff member or volunteer in respect of any immediate action that needs to be taken.
  6. The Designated Manager will ensure that a Director of Care is informed of any implementation of the Safeguarding Policy.
  7. It is not expected that the Designated Manager will be necessarily responsible for taking further action nor will they always have access to any computer or paper-based information such as details of local statutory service providers.
  8. The Designated Manager will log the call and follow-up the staff member or volunteer the next day to ensure that the call has been made and support given as necessary.
  9. A record of the situation and actions taken will be recorded on MrC under 'safeguarding notes'. Heads of Regional Care Partnerships (HoRCP) and Area Support Coordinators (ASCs) must also enter the details onto the Association's Safeguarding Log.
  10. **Staff outside of the Care Directorate**, should alert the ASC and/or HoRCP responsible for the geographical area in which the safeguarding concern has taken place, to ask them to place a safeguarding note on both the individual's MrC record and onto the Safeguarding Log.
  11. Staff and volunteers should never feel inhibited to seek advice and guidance about any concern for the safety and wellbeing of an adult at risk of harm.
- 5.7** All concerns regardless of whether they lead to a referral should be discussed with a line manager as soon as possible. A decision should then be made about whether a referral is appropriate. This is the same for all Directorates.
- 5.8** For **volunteers**, the immediate line manager is defined as follows:
- For all **Support Volunteers, including Association Visitors**, it is the MND Connect Helpline, their Area Support Coordinator (ASC) or the emergency out-of-hours response service, who in turn, will report to the Designated Safeguarding Manager.
  - For **Branch and Group volunteers and supporters** it is MND Connect helpline, who in turn would report to the Designated Safeguarding Manager.
  - For **Trustees**, it is the Director of Care Improvement.
- 5.9** A telephone call to the relevant Adult Social Care service or the Police should be the first action when initiating a referral during office hours; outside of office hours the referral will be made to the Social Care Emergency Duty Team or the Police. The

Designated Safeguarding Manager (DSM) will make the referral on behalf of staff, as appropriate. In general Care Directorate staff will make the referral directly, with support as appropriate, whilst for all other Directorates, the DSM will make the referral, on their behalf.

- 5.10** It is the responsibility of the duty social worker taking the referral to assess the risk to the adult at risk of harm. All referrals should be followed up with a written referral. Note: staff/volunteers should provide as much detail as they have. It can be helpful to make accurate notes on what the individual adult making an allegation said to you.

**It is worth remembering that in most cases the individual and family of concern need support. Services will often work with the family, not against them.**

- 5.11** The person making the referral should, in turn, be given details from Social Care, the Emergency Duty Team or Police Officer receiving the referral. A record of the conversation with the statutory agency, including the person's name, telephone number, time and outcome should be logged in MrC under 'safeguarding Notes'. You may find the Safeguarding Recording Guidance in [Appendix 3](#) helpful.
- 5.12** The written 'referral form' to Adult Social Care should be completed by the person initiating the referral immediately following the telephone referral. Please use the link below. *Note: if Social Care request that their own referral form is used, then please use their form (in this case, staff do not need to complete the MND Association referral form).*

#### [Safeguarding Adults Referral Form](#)

- 5.13** The immediate line manager, in consultation with the Designated Safeguarding Manager, will be available for advice and guidance throughout. Additional assistance to complete the referral form will be available to all Care Directorate staff as appropriate. **For those staff from other Directorates, the Designated Safeguarding Manager will complete the form and send to the appropriate social care agency.** Volunteers will not be expected to complete a referral form.
- 5.14** The referral should be followed up with the statutory agency in question a month later, and any outcome recorded in the Association's Safeguarding Log. In the majority of cases, you will be told that 'no further action' has been taken. If, however, you are not satisfied with this response, escalate to your line manager who will liaise with the DSM, to challenge Social Care's decision.

## Confidentiality

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- 5.15** Disclosure by an adult at risk of harm, abuse, ill treatment or neglect, and the consequences of such a disclosure is not easy. It is likely to have profound effects

on that individual and other family members. It may be difficult for them to agree to a referral to statutory services.

- 5.16** All adults at risk receiving support or services from the MND Association must be made aware that complete confidentiality is not possible where there is risk of significant harm or abuse to them or any other individual. [Please refer to the Association's Confidentiality and Data Protection Policies for details.](#)
- 5.17** Where an individual has not consented to sharing information for a referral the reasons for the referral need to be clearly explained to them so that any ongoing/future supportive relationship can be maintained as far as is possible.
- 5.18** Any decision to breach or not to breach confidentiality, together with those reasons for doing so, must be recorded in the safeguarding notes on MrC.
- 5.19** **Under no circumstances should an alleged abuser be alerted, directly or indirectly, that concerns have been raised.** This may result in important evidence being lost, or further risk to the adult in question. Formal investigations will be carried out by the appropriate statutory agencies.
- 5.20** **It is good practice to inform an adult at risk that a safeguarding referral concerning them is being made,** dependent on the capacity and understanding of the adult. It should be made clear that it will be a statutory agency that will make a decision about what help and support they need to stay safe.

## **5.21 Safeguarding and General Data protection Regulations (GDPR)**

Any safeguarding concerns you have should always take precedence.

- Don't avoid sharing a safeguarding concern with your manager because you are worried about contravening GDPR.
- We should always try and share a safeguarding concern with the person's permission where at all possible (unless this would put an adult at further risk of harm).
- If we do have to breach their confidentiality, then the onus is on us to explain why we have done that, under GDPR.
- Always seek guidance and advice from your line manager in such circumstances – and refer to the Association's relevant policies and procedures.
- Providing an individual has mental capacity, we have a duty to promote independence and to recognise that adults are best placed to judge their own well-being.
- However, there are a number of circumstances, in which we might decide to share information with other agencies, without explicit consent, including:
  - we have reason to believe an adult does not have capacity.
  - others may be at risk of harm.
  - a crime could be committed.
  - the alleged abuser has care and support needs.

- a serious crime has been committed.
  - staff are implicated.
  - an adult has mental capacity but may be under duress or being coerced (e.g. domestic violence).
  - the risk is unreasonably high and meets criteria for a multi-agency risk assessment conference or
  - there is a court order.
- Where we choose to breach confidentiality and share information without consent, we must record our reasons for this on the safeguarding written referral form and in the 'Safeguarding Notes' on MrC.

## Informing your Manager of the Referral

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- 5.22** On completion of the written referral form it should be sent to the Designated Safeguarding Manager (DSM). The DSM should check that the referral form contains all relevant information about the concern discussed, including contact information for adult social care should they need further contact with the Association. Where necessary the DSM will provide support to Care Directorate staff to complete the referral form. Additional assistance will be provided to all volunteers, who will not be expected to make a safeguarding referral.
- 5.23** The referral should be sent by the DSM, as a PDF document, via secure email, to Adult Social Care.
- 5.24** All safeguarding referrals should be recorded within the Association's central Safeguarding Log

## Recording Guidance

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- 5.25** Whenever concerns are raised about an adult at risk, whether through an allegation or the observation of a set of circumstances, it is crucial to make and keep an accurate record - see [Appendix 5 General Principles of Recording](#). Line managers must use the staff and volunteer supervision and support structures to address safeguarding practice issues and concerns.
- 5.26** The following guidance should be followed:
- Whenever possible and practical, take notes during any conversation.
  - Ask for consent to do this and explain the importance of recording information.
  - Explain that the person giving you the information can have access to any information about them.

- Where it is not appropriate to take notes at the time, make a written record as soon as possible afterwards and always before the end of the day.
- Record the time, date, location, format of information (e.g. letter, telephone call, direct contact) and the persons present when the information was given.
- Include as much information as possible but be clear about which information is fact, hearsay, opinion and do not make assumptions or speculate.
- Include the context and background leading to the concern or disclosure.
- Include full details of referrals to Adult Social Care and the Police.

**5.27** If the adult is not a service user and does not have a contact record on MrC, a new contact record must be made which will be kept securely and will contain all records, logs, events and information relating to the particular adult as appropriate.

## Allegations against staff or volunteers

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**5.28 Allegations about staff or volunteers abuse of an adult** must be raised immediately with Director of Care Improvement who will alert the appropriate agency. The Director in consultation with HR, will decide whether to suspend or remove the employee or volunteer from active service pending the outcome of an investigation.

**5.29** If a Director of Care is suspected of abuse, this should be reported to the Chief Executive.

**5.30** If a Trustee or Chief Executive is suspected of abuse this should be reported to the Chair of Trustees, supported by the Director of Care Improvement. If a Chair of Trustees is suspected of abuse this should be reported to the Charity Commission.

**5.31** Personal information may be disclosed without the individual's consent if there are reasonable grounds to believe that an individual is at risk of harm ([see Confidentiality and Data Protection Policies](#)).

**The procedures for managing allegations of abuse against a staff/volunteer abusing or harming an adult at risk** is set out in [Appendix 4: 'Allegations against MND Association Staff/Volunteers'](#). See also the ['Flowchart: procedure for allegations made against staff or volunteers.'](#)

## 6. Supporting Individuals who may be at risk of suicide

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Please refer to separate guidance for MND Association staff and volunteers.

## 7. Supporting Policies

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Recruitment and Training Policy.  
Confidentiality Policy.  
Recruitment of Offenders Policy.  
Grievance & Disciplinary Policy.  
Disclosure Policy and DBS Vetting of identified posts.  
Whistle Blowing Policy.  
Equality & Diversity Policy.  
Complaints Procedure.  
Volunteering Policies.  
Data Protection Policies.  
Lone Working Policy.  
Suicide Guidance for Staff and Volunteers

## 8. Risk Assessment

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The risks of not observing this safeguarding policy, include:

- Abuse or harm to an adult at risk.
- Potential damage to the reputation of the Association.
- Potential risk of legal action.
- Loss of confidence and trust in the Association.

## Making a Safeguarding Referral– Adult at Risk of Harm

Appendix One

