

Safeguarding – Reflecting on Practice

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Abstract

The focus of this reflection is around an allegation of neglect. Using Gibbs' model of reflection has enabled the author to systematically explore the issues. It will explore some of the challenges that can be experienced by a practitioner when managing such issues. There is acknowledgement of the need for organisational and individual change if we are to improve practice in the management of safeguarding issues. It is recognised that we need to be able to identify the challenges and opportunities in the first instance if we are to improve practice.

Keywords

Safeguarding; Inter-agency working; Decision Making; Assessment

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This article reflects on an incident which occurred within the community concerning an allegation of neglect and the subsequent concerns raised regarding safeguarding issues. National and local safeguarding policies such as the ‘Safeguarding Children and Young People’ toolkit for general practice (Royal College of General Practitioners and National Society for the Prevention of Cruelty to Children (RCGP and NSPCC) 2014) will be critically analysed and Gibbs’ (1988) model of reflection will help to understand the situation. Individual and organisational changes will be considered and their influence on improving future outcomes along with implications of management decisions relating to this incident. In line with the Nursing and Midwifery Council (NMC) Code of Conduct (2015), confidentiality will be maintained. A pseudonym of ‘Liam’ will be used when referring to the child who was a baby aged thirteen months.

Working as a practice nurse in a busy, inner-city practice can be challenging as the role involves interaction with patients of all ages, ethnicities and cultures. A large part of this role requires collaboration with other agencies to ensure continuity of patient care. In this incident, a letter was received at the surgery from an Accident and Emergency department detailing Liam’s attendance with perianal thrush. There was a statement explaining concerns for Liam’s unkempt appearance, which suggested the presumption of neglect (Hunt 2014) and questioned whether our surgery had any safeguarding concerns. Neglect is the persistent failure to meet basic physical/psychological needs (Department of Education 2015). The family were newly registered with the surgery; however, the child was not known to the clinicians. Therefore, this letter from an Accident and Emergency department formed the basis of this allegation.

A previous consultation was documented for the child’s mother regarding her mental

health. Her lack of engagement was noted by the General Practitioner as was the domineering attitude of her partner. Parental mental illness is a common risk factor in child neglect (Webber, McCree and Angeli 2013) as well as domestic violence (Parton, 2011) supporting the need for these heightened concerns. However, these suspicions were raised from professional documentation alone. Relying on documentation alone may lead to difficulties forming balanced views while trying to protect Liam. The investigation was challenging due to the health visitor's limited contact with the family and inability to access previous health-visiting notes as the family had recently moved into the area.

Hunt (2014) states information sharing between professionals is vital for effective safeguarding, yet even at an intra-agency level between two health-visiting teams this was not possible due to incompatible computer systems. IT systems that facilitate safe information sharing could have allowed for more proficient information sharing and earlier intervention. Information sharing between professionals is paramount (Department of Education 2015) and having one accessible multi-agency file would secure this process (Hunt 2014). Laming (2003) supports this, proposing a national database for accessing information regarding all children as this would ensure those moving across localities would remain detectable. However, this would be challenging to create (House of Commons Health Committee 2003). NHS England created the local 'Child Health Information system', a database detailing vaccination history and current safeguarding alerts but it is not widely available. With issues such as confidentiality and access rights affecting its expansion (El-Radhi 2015), it will be some time before it is widely accessible.

An integrated system would allow agencies to interact more successfully, will ultimately improve practice. Dunne and Finalay (2016) support this notion stating information sharing in a timely and effective way between agencies can lead to higher quality safeguarding responses. Through an integrated system, this could be achieved as all appropriate staff would have the ability to promptly view patient case histories and upload essential information. This should not surpass the need for dialogue between multi-agency staff as this is equally important in attaining a fuller picture (Webber, McCree and Angeli 2011). The need for quality inter-agency collaboration and information sharing is clearly evident if effective safeguarding practice is to be achieved. Our local safeguarding policy incorporates the 'Safeguarding Children and Young People' toolkit for general practice (RCGP and NSPCC 2014) including processes for early intervention, referral and service requirements. It advocates the use of an 'Early Help Assessment Tool' (EHAT) for identifying children's needs, inter-agency collaboration and coordination (RCGP and NSPCC 2014). This can be used by all agencies, allowing for collation of relevant information. In practice, however, this tool is not fully utilised, possibly due to time constraints and competing priorities (Peckover and Golding 2015). The priority for a hospital doctor may vary from that of a practice nurse running a routine vaccination clinic; however, Laming (2003) states that no set of responsibilities is subordinate to another and agencies have equal responsibility (RCGP and NSPCC 2014). Utilisation of appropriate guidance to standardise practice, therefore, is essential (Webber, McCree and Angeli 2013).

The toolkit focuses on inter-agency collaboration and documentation, common themes highlighted in the 2003 'Every Child Matters' Green Paper (HM Treasury 2003) and

supported by the 'Working to Safeguard Children' document (Department of Education 2015). Inter-agency working between services such as practice nurses, health visitors and social workers, is vital for creating a wider picture but unfortunately, despite Government legislation and policy intention, service gaps remain (Maddams 2013), particularly with the sharing of information. Patient records/letter/documentation, once received at the surgery, are processed by administrative staff before reaching the clinician which can cause information to be delayed or omitted. This highlights the importance of ensuring robust systems and processes are in place. Electronic records may help to speed up this, but there are challenges of hacking, viruses along with system failure which leads to no access until repairs completed.

It is well recognised that interdisciplinary working is essential (Day, Bantry-White and Glavin 2010) and this cannot be achieved where agencies work alone (Laming 2003). Although more information creates deeper insight for investigation (Herbert et al. 2014) problems with confidentiality and inter-agency gaps remain a challenge (Darlington, Feeney and Rixon, 2005). Using the previously mentioned EHAT can bridge these gaps, enabling agencies to collate all concerns at a central point, namely Social Services (RCGP and NSPCC 2014).

Attendance at multi-agency child protection case conferences where cases are discussed and management proposals offered between agencies is another area highlighted within the EHAT as essential for effective safeguarding yet this is an area where improvements could be made in general practice. There will often be differing perceptions of how to manage 'at-risk' children (Liverpool City Council 2014) and attendance at conferences enables sharing of information between agencies so that

decisions can be reached based on all available information from agencies (RCGP and NSPCC 2014). Case discussions with other agencies are also paramount (Laming 2003)

Feelings

A vital component of a practitioner's role involves reflecting on thoughts and feelings which guide decisions (Jones 2007). As a practitioner reflection is an essential part of practice; however, decisions around safeguarding concerns can be distressing for those working in healthcare (Sturdy 2012). Gibbs' (1988) model of reflection has, therefore, aided critical analysis and evaluation of this incident. On reflection, the initial feeling was one of frustration at being left to undertake responsibility for managing this safeguarding issue instigated by another professional's concern. Safeguarding is everyone's responsibility (Webber, McCree and Angeli 2010) yet actions that could have been taken by the hospital were not. Nurses have a duty to act in the patient's best interests (NMC 2015); supported by the General Medical Council (GMC 2014) Code of Conduct, the regulator of practising doctors.

This was incorporated with a feeling of the magnitude of the task and associated accountability. Munro (2010) explains the very nature of safeguarding is exacerbated by high levels of scrutiny (from colleagues, social services and health visiting services), and this was evident by my apprehension at having to make those decisions. Referring Liam to Social Services, an agency accountable for managing safeguarding issues on a daily basis, brought an anticipated feeling of incompetence in my own judgement. This prompted the question as to whether the correct course of action was to make this referral, knowing the potential impact this would have on Liam and his family. In light of

the concern, however, and with a duty of care owed to the child a referral was deemed unavoidable.

Evaluation and Analysis

On reflection, following local policy clarified the process for me in managing this case. The lack of information sharing, however, particularly with the health visitor, as well as poor documentation from the hospital made gaining an insight into events challenging. This contributed towards feelings of anxiety in making decisions. Ruch (2012) supports this stating anxiety can affect capacity to think clearly. The lack of collaboration acted as a barrier in the process but following the local safeguarding policy provided some clarity. The main concern was for Liam's welfare although feelings of guilt were prominent. In general practice, building relationships with families is paramount (Wainwright and Gallagher 2010) making families more likely to engage (Woodman, Rafi and De-Lusigan 2014). Barriers were made before the family had even engaged with the practice decreasing the likelihood of relationship-building. On analysis, however, if Liam was at risk, engagement with social services may have triggered the family to engage with services facilitating them to receive the help and support needed to ensure Liam's safety.

Conclusion and action plan

In conclusion, a referral to Social Services could have been delayed and a surgery consultation arranged to gain more information. In doing so, a referral may have been avoided until a more detailed picture may have emerged through interaction with the family. Observation of the family during a consultation would have allowed for

assessment of the parent/child interaction and potential neglect. Engaging with the family may have also altered judgements, during relationship building with the parents (Wainwright and Gallagher 2010) potentially influencing decisions to refer/not to refer. On balance, however, a combination of family interaction prior to referral to gain more insight along with better inter-agency collaboration would have been the best course of action, but the family's change of address created an interruption to the potential for this.

Both organisational and individual change is required if safeguarding practice is to advance. Individual perceptions and demographic influences in relation to safeguarding play a role in how situations are viewed (Herman-Smith 2013). In the case of Liam, there may have been a variety of views between the hospital and general practice with regard to the level of safeguarding concerns.

There is a media influence which affects our perception of abuse, and physical and sexual abuse tend to be higher on the list. This is supported by Davies, O'Leary and Read (2015) who state neglect and emotional abuse, are relatively invisible in the media but sexual abuse is commonly reported. Neglect may be viewed by some as 'less damaging' and not as harmful (Kendall-Taylor, Lindland and O'Neil 2014) hence more acceptable to some. Definitions of neglect can vary between individuals (Kendall-Taylor, Lindland and O'Neil 2014) and are often influenced by organisations, media and cultural directions. It is a challenge to change individual perceptions but through shared learning (Domac and Haider 2013) and improved training (Day, McCarthy and Leahy-Warren 2009) this could be more achievable. Changing individual perceptions is required if there is any hope of organisational change.

As Government legislation repeatedly advises, inter-agency working is a major factor which needs improvement (Laming 2003). Safeguarding requires a team approach (Maddams 2013) and an appreciation of the different roles required to produce this effective inter-agency working (Peckover and Trotter 2015) but is not always realistic or wholly achievable in practice. Practitioners are generally mindful that inter-agency working can create an enhanced safeguarding service yet it is difficult to achieve. Barriers such as time limitations and work pressures (Woodman, Rafi and De-Lusigan 2014), lack of knowledge and effective training (Hunt 2014), and separate protocols (Webber, McCree and Angeli 2013) are just some of the areas which need addressing to establish effective inter-agency working.

Individual case-loads and other responsibilities can limit opportunities to interact fully with colleagues, especially when this often requires leaving messages and awaiting correspondence from colleagues who are equally stretched to their limits. There are also multiple places patients can access care including hospitals, walk-in centres and general practice to name but a few. This widens the possibility that safeguarding issues can be missed as communication between services can be fragmented. Each service is juggling its own organisational and professional priorities hence there may be differences with the importance given to safeguarding issues (Peckover and Golding 2015). Making a conscious effort to liaise effectively with colleagues, however, will go some way to influencing organisational change.

On evaluation of the management decisions with regards to Liam, the hospital's documentation was fundamental yet inadequate creating challenges in its interpretation. From a nurse perspective, the Code of Conduct (NMC 2015) stipulates the importance

of concise documentation, particularly in safeguarding (Mott and Thomas 2014). Poor documentation could potentially have hindered further investigation of this case, potentially delaying any referral/intervention from the statutory services for Liam.

Another barrier was a lack of inter-agency collaboration, mainly associated with difficulties gaining patient notes from across boundaries. Fears over information sharing should not hinder safeguarding investigations (Department of Education 2015) and this is supported through local policy but unfortunately it proved challenging in practice.

Devaney (2008) describes health visitors as feeling GPs act on the periphery of safeguarding, thus creating power imbalances between services with health visitors feeling they have 'more right' to the information. This should not be the case as all parties should have equal access to information for safeguarding to be effective (Woodman et al. 2012). Creating better working relationships with health visitors would improve information sharing and Herbert et al. (2014) feel this would be a logical development.

In recent weeks, arrangements have been made within practice to initiate monthly safeguarding meetings with our health visiting team. This will not only improve services in line with local policy through information sharing but also create a safer service for patients. It will also go some way to improving collaboration across boundaries and with services such as walk-in centres and hospitals as inter-agency involvement expands.

Lack of an appointed safeguarding lead was also flagged as an issue which needed addressing in light of the local policy. A safeguarding lead can offer appropriate advice and support (Sturdy 2012) allowing ideas to be shared and support for professionals (Morris-Thompson et al. 2012) but currently this position does not exist in the surgery.

As information is often ambiguous and incomplete with safeguarding (Galpin and Hughes 2011) the need for a lead would enable practitioners to gain direction (El-Radhi 2015). No one can be an 'expert' in safeguarding and it would be wrong to assume this would determine the criteria for the position but having that support when required would assist clinicians, providing a point of support/advice when they encounter such issues in practice. This would subsequently lead to safer practice.

In conclusion, our local policy proved successful in managing these safeguarding issues for Liam. It aided decision-making and displayed both individual and organisational requirements. As a result of the referral to Social Services it was identified that the family required further support and education which was implemented with agreement from the family. Reflecting on this case has allowed for issues such as inter-agency collaboration, information sharing and service gaps to be raised. It has also highlighted how individual perception can influence patient outcomes. There are many changes still to be made to improve safeguarding practice and as Ruch (2012) recognises, these changes require time and work. Recognition of practice weaknesses is the first step to change, however, and only then can we begin to improve patient care.

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