

Safeguarding Vulnerable Adults Policy

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Related Policies & Guidelines:

- Safeguarding Children Policy

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Amendment History

Version	Status	Date	Reason for Change	Authorised
1.0		December 2014	Initial policy for consultation	

1. Policy Summary

The purpose of this document is to ensure that Central London Healthcare CIC (CLH) meets nationally recognised and regionally agreed best practice for safeguarding vulnerable adults. Whilst the responsibility for coordinating Safeguarding Adults" arrangements lies with Borough councils with social care responsibilities, effective safeguarding is based on a multi-agency approach.

This policy has brought together recent guidance from the Department of Health on Safeguarding Adults. This includes: the role of NHS commissioners, health service managers and practitioners in preventing and responding to neglect and abuse, focusing on patients in the most vulnerable situations. The documents include good practice principles and examples which have been incorporated in to this policy.

Using the Clinical Governance and Adult Safeguarding Department of Health paper, this policy also aims to integrate these two approaches with the desired outcome of greater openness and transparency about clinical incidents, learning from safeguarding concerns that occur within CLH and its health and social care partners, clarity on reporting and more improved positive partnership working.

This policy should be read in conjunction with the Department of Health guidance "No Secrets" and the Pan-London multi-agency policy and procedures, and other national and local guidance, primarily but not exclusively:

- Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse. *SCIE 2011*.

The policy applies to all CLH staff.

Implementation of this policy will ensure that:

- All staff are aware of how to recognise and report issues of abuse and neglect to those adults who are vulnerable as defined by 'No Secrets'.
- Service Users/Patients are able to contribute and are involved in Safeguarding Investigations.
- Staff work in a preventative manner to protect vulnerable adults from being abused.
- There is consistency of reporting and procedures across health, social care and other partner agencies locally.
- There will be an increase in staff awareness of vulnerable adult issues.
- CLH is compliant with the CQC essential standards relating to Safeguarding Adults.

2. Policy Statements

This document sets out the CLH system for safeguarding vulnerable adults from abuse and neglect. It provides a robust framework to ensure a consistent approach across the whole organisation, and supports our statutory duties as set out in the NHS Constitution.

CLH is committed to improving the quality of health and social care, developing accountability to patients and strengthening the choice and control they have over their care.

The Government has agreed principles for safeguarding adults that can provide a foundation for achieving good outcomes for patients.

2.1 Principle 1: Empowerment – Presumption of person-led decisions and consent

Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

2.2 Principle 2: Protection – Support and representation for those in greatest need

There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

2.3 Principle 3: Prevention

Prevention of harm or abuse is a primary goal. Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health services.

2.4 Principle 4: Proportionality – Proportionality and Least Intrusive Response Appropriate to the Risk Presented

Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

2.5 Principle 5: Partnerships – Working in a multi-disciplinary approach

Safeguarding adults will be most effective where services work collaboratively to prevent, identify and respond to harm and abuse.

2.6 Principle 6: Accountability – Accountability and transparency in delivering safeguarding

Services are accountable to patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

3. Definitions of Terms Used

3.1 Vulnerable Adult

The broad definition of a “vulnerable adult” is taken from *No Secrets* Section 2.3:

*A person who is over 18 years old and who is or may be in need of community care services by reason of mental or other disability, age or illness, **and** who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”.*

The term “community care services” includes all social and health care services provided in any setting or context. [See *No Secrets* Section 2.4.]

The last two parts of the definition are crucial:

- Is this person dependent on others for basic needs including protection from abuse [i.e. is or may be unable to take care of him/herself]; **OR**
- Because of circumstances [e.g. living in a care setting, does not have capacity to decide on risk, is under duress from others] they are unable to protect themselves against significant harm or exploitation.

3.2 Types of Abuse

The following definitions are covered by this policy:

- **Physical abuse** - including hitting, slapping, pushing, kicking, misuse of medication or inappropriate sanctions or restraint.
- **Sexual abuse** - including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent or was pressured into consenting.
- **Psychological abuse** - including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation or blaming.
- **Financial or material abuse** - including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits.
- **Neglect and acts of omission** - including ignoring medical or physical care needs, failure to provide access to appropriate health, social care, or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **Discriminatory abuse** - including abuse motivated by discriminatory and oppressive attitudes towards race, gender, cultural background, religion, physical and/or sensory impairment, sexual orientation and age. Discriminatory abuse manifests itself as physical abuse/assault, sexual abuse/assault, financial abuse/ theft and the like, neglect and psychological abuse/harassment, including verbal abuse.
- **Institutional abuse, neglect and poor professional practice** – including abuse that takes the form of isolated incidents of poor or unsatisfactory professional practice at

one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other.

3.3 Significant harm and serious exploitation

Significant harm and serious exploitation are defined as:

‘Any ill treatment that leads to the impairment of or avoidable deterioration in the individual’s physical or mental health, or the impairment of or avoidable deterioration in physical, intellectual emotional social or behavioural development’
[Who Decides, Lord Chancellor’s Department 1997]

The process of assessing significant harm will include consideration of the following factors [Appendix 1 will assist in differentiating poor practice from potential safeguarding issues]:

- The vulnerability of the adult according to the eligibility criteria of the
- National Health and Community Care Act 1990.
- The apparent impact of the abuse on the vulnerable adult.
- The risk of repetition or escalation of abuse involving increasingly serious acts or the extension of the abuse to other vulnerable adults or children under the age of 18.
- The correlation between the outcome of the assessment and the depth and conviction of the feelings expressed by the person reporting the alleged abuse.

4. Duties and Responsibilities

4.1 Medical Director

Dr Matthew Johnson provides the safeguarding lead for Central London Healthcare.

4.2 Safeguarding Adults Lead Nurse

The Safeguarding Adults Lead Nurse for Central London CCG is Julie Dalphinis (Julie.dalphonis@nhs.net)

4.3 The Senior Management Team

The Senior Management Team are responsible for ensuring that there is adherence to the policy by their staff. They are responsible for signing off local induction which ensures that staff are aware of the policy and know where to find supporting information, and updates the staff with any changes.

4.4 All staff

All staff have a responsibility to report any actual or suspected case of adult abuse to the most senior person on duty in their area.

5. Main Body of Policy

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well-being. Healthcare staff are often working with patients who, for a range of reasons, may be less able to protect themselves from neglect, harm or abuse. Safeguarding adults concerns vary according to the nature of harm, the circumstances it arose in and the people concerned.

Safeguarding adults is about the safety and well-being of all patients but providing additional measures for those least able to protect themselves from harm or abuse.

Degree of harm

Some concerns may be minor in nature but provide an opportunity for early intervention for example, advice to prevent a problem escalating. Other safeguarding concerns may be more serious and need a response through multi agency procedures and possible statutory intervention through regulators, the criminal justice system or civil courts.

Type of harm and abuse

Harm or abuse can take place in a wide range of settings such as within regulated services and within people's own homes. The cause of harm and abuse may similarly be wide ranging e.g. harm caused unintentionally by an unsupported carer; neglect caused by staff or a service; abuse which is caused through recklessness or is intentional.

Source of harm and abuse

Harm or abuse can take place in a wide range of settings such as within regulated services and within people's own homes. The cause of harm and abuse may similarly be wide ranging, e.g. harm caused unintentionally by an unsupported carer; neglect caused by staff or a service; abuse which is caused through recklessness or is intentional.

Who may require support in keeping themselves safe?

Many patients are able to safeguard their own interests and protect themselves from neglect, harm or abuse. However, some adults are in vulnerable situations and are less able to protect themselves or make decisions about their safety. Hospitalisation alone can result in a degree of vulnerability not normally part of the person's life when they are in their own home.

Timely assessment will identify adults in the most vulnerable circumstances and use person centred care to reduce the risk of neglect, harm and abuse.

Safeguarding adult's multi agency procedures apply where harm or abuse has occurred [or is suspected] to adults currently defined within *No Secrets* [See definitions above for *No Secrets* definition of a Vulnerable Adult, Abuse and Significant Harm].

Applying 'No Secrets' definitions within healthcare settings

Eligibility for social care [community care services] focuses upon the immediate or longer term risk to a person's independence and well-being.

A patient's need for social care will vary by degree and across time but many may fall within the scope of adult protection. Levels of independence and wellbeing may be temporarily or permanently affected by health related conditions. A patient's health condition may reduce the choice and control they have, their ability to make decisions or to protect themselves from harm and exploitation.

Consequently, the definition of 'vulnerable adult' may apply broadly within healthcare.

Why is safeguarding adults important to patient care?

Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the Health and Social Care Providers. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost effective care.

Learning from high profile inquiries identified recurrent themes in the failures of care:

- Patients are not empowered to make choices about their care and protection.
- Patient's voice is not heard.
- Neglect and abuse arise in the absence of effective prevention and early warning systems.
- Neglect and abuse are not always recognised by health care staff.
- Lack of transparency and openness in investigation – incidents are not well managed through multi agency safeguarding adult's procedures.
- Safeguarding adults is seen as the responsibility of others.

Inquests, enforcement measures by regulators and prosecutions by the courts highlight the cost to health services and to the professionals within them, where duties to safeguard adults are not met.

Integrating clinical governance and adult safeguarding

The Department of Health published a report on the outcomes of the review of the 'No secrets' guidance in July 2009. The report highlighted that there was a perception across all agencies that incidents within the NHS were largely dealt with 'in-house' through clinical governance systems and were rarely thought of in the wider safeguarding context.

There are opportunities to be gained from streamlining and integrating systems where investigations can be undertaken in parallel and the learning from both can be informative and help to develop communication between safeguarding teams and health agencies. A clear distinction needs to be made between the two processes to avoid duplication and to use opportunities where one investigative process can meet the requirements of both sets of procedures. It is recognised the potential high level of adverse incidents that would be reportable as safeguarding concerns if the two processes came together.

In organisations as large and complex as the NHS, things will sometimes go wrong. Incident reporting is one of the key methods for alerting other parts of the organisation to issues that if left unattended may pose a risk in future to patients or the health and safety of staff, visitors, contractors and others.

The purpose of the reporting system is to enable the NHS to actively learn from incidents and to ensure that where required changes are identified they become embedded in practice. This includes

those incidents that occur on NHS premises, in the provision of NHS commissioned services or when an NHS employee is carrying out a work-related task on non-NHS premises.

The process and reporting outlined below considers the clinical governance process within the safeguarding process.

5.1 What to do when abuse is suspected

Everyone with a duty of care to an adult at risk should:

- act to protect the adult at risk
- deal with immediate needs and ensure the person is, as far as possible, central to the decision making process
- report the abuse to an appropriate person or service (e.g. your line manager)
- if a crime has or may have been committed, contact the police to discuss or report it
- make a clear record of the events.

A concern may be a direct disclosure by the adult at risk, or a concern raised by staff or volunteers, others using the service, a carer or member of the public, or an observation of the behaviour of the adult at risk, or the behaviour of another.

All staff (professionals and volunteers) of any service involved with adults at risk should inform the relevant manager if they are concerned that an adult has been abused or may be at risk of harm.

For further details, refer to the SCIE guidance:

<http://www.scie.org.uk/publications/reports/report39.pdf>

5.2 How to make a report of suspected abuse

Professional Standards and Safeguarding Team

Tel: 020 7641 5222

Email: safeguardingadults@westminster.gov.uk

Contact the out of hours team on 020 7525 5000 (Weekdays: 5pm to 9am; Weekends and bank holidays: 24 hours)

For Westminster safeguarding referrals: adultsocialcare@westminster.gov.uk

5.3 Consent

Capacity and consent, and the sharing of information

Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery, including decisions around the sharing of information. Consent must be documented in patient notes.

Consent to refuse support/intervention

Some vulnerable adults may refuse intervention and support from professionals, one of the starting points is to understand whether the patient has the mental capacity to make the particular decision at that time.

Situations where the vulnerable adult does have capacity

If it is decided that a person does have capacity and has taken an informed choice to live in a situation that puts them at risk, then the person, their carer, their community support and any other relevant agency or individual should be consulted in order to ensure that the person is offered all possible choices. He or she may still choose to stay in the situation and live with that risk.

Workers will need to determine whether the vulnerable adult is making the decision of their own free will or whether they are being subjected to coercion or intimidation. If it is believed that the vulnerable adult is exposed to intimidation or coercion, efforts should be made to offer the adult 'distance' from the situation in order to facilitate decision making.

Situations where the vulnerable adult does not have capacity

If it is decided that the vulnerable adult does not have capacity then staff should act in the best interests of the vulnerable adult, and do what is necessary to promote health or wellbeing or prevent deterioration.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions and is underpinned by five key principles:

1. A presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. Individuals must retain the right to make what might be seen as eccentric or unwise decisions.
4. Best interests – anything done for or on behalf of people without capacity must be in their best interests.
5. Least restrictive intervention - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a "decision specific" test. No one can be labelled "incapable" as a result of a particular medical condition or diagnosis. The Act makes it clear that a lack of capacity cannot be established merely by reference to a person's age, appearance, or any other condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.

A person lacks capacity in relation to a specific matter if he/she is unable to:

Make a decision for him/herself in relation to the matter because of impairment or a disturbance in the functioning of the mind or brain [Mental Capacity Act 2005].

- Understand the information relevant to make the decision.
- Retain the information.
- Use or weigh that information as part of the process of making the decision.
- Communicate their decision, whether by talking, using sign language or any other means [Mental Capacity Act 2005]

6. Training

Managers are responsible for ensuring all their staff receives the type of initial and refresher training that is commensurate with their role(s).

Bespoke sessions can be facilitated when needed.

Appendix 1 – Examples of when the Safeguarding Adults Procedure May or May Not be Needed

The difference between poor practice and neglect is much contested. If a person is totally dependent on others' assistance to meet basic needs, continual "poor practice" can lead to serious harm or death.

Useful elements in deciding if poor practice has occurred which does not require a safeguarding adults response are to ascertain if the concern:

- is a "one off" incident to one individual
- resulted in no harm
- indicated a need for a defined action

Examples of the difference between poor practice and neglect can be seen below. The left hand column provides examples of poor practice which would still require addressing internally; the right hand column provides examples of when that poor practice crosses the threshold to become a possible safeguarding adult's issue.

With all the examples on the right, if they are a common occurrence in the setting, or there are no policies/protocols in place or not just being perpetrated by one member of staff, this will potentially pass the threshold for whole service investigation.

Allegations which may NOT pass the threshold for use of the Safeguarding Adults procedure	Allegations which WILL pass the threshold for use of the Safeguarding Adults procedure
Poor practice: Person does not have within their care plan/service delivery plan/treatment plan a section that addresses a significant assessed need such as: <ul style="list-style-type: none"> • management of behaviour to protect self or others 	Possible abuse: Failure to specify in a persons' plan how a significant need must be met. Inappropriate action or inaction related to this results in harm
Poor practice: Person's needs are specified in treatment or care plan. Plan not followed, needs not met as specified but no harm occurs.	Possible abuse: Recurring event, or is happening to more than one adult. Harm: weight loss, hunger, thirst, dehydration, malnutrition.
Poor practice: Person is spoken to once in a rude, insulting and belittling or other inappropriate way by a member of staff. Respect for them and their dignity is not maintained but they are not	Possible abuse: Recurring event, or is happening to more than one person. Insults contain discriminatory, e.g. racist, homophobic abuse. Harm: distress, demoralisation, other abuses

distressed.	may be occurring as rights and dignity are not respected.
Poor practice: Person does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs.	Possible abuse: Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk. Harm: missed medication and meals, they are put at risk of significant harm including neglect.

Appendix 2 – References

Care Quality Commissions, Essential Standards

<http://www.cqc.org.uk/content/essential-standards>

Clinical governance and adult safeguarding: an integrated process, Department of Health, Guidance for Healthcare

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215713/dh_125035.pdf

NHS and Community Care Act, 1990

<http://www.legislation.gov.uk/ukpga/1990/19/contents>

No Secrets, DH 2000 & No Secrets Guidance, DH 2009

<https://www.gov.uk/government/publications/no-secrets-guidance-on-protecting-vulnerable-adults-in-care>

SCIE Adult Safeguarding: Policy and procedure

<http://www.scie.org.uk/publications/reports/report39.pdf>

Who Decides, Lord Chancellor's Department 1997

<http://webarchive.nationalarchives.gov.uk/+http://www.dca.gov.uk/menincap/meninfr.htm>

Mental Capacity Act 2005

<http://www.legislation.gov.uk/ukpga/2005/9/contents>

Deprivation of Liberty Safeguards

<https://www.gov.uk/government/publications/mental-capacity-act-deprivation-of-liberty-safeguards>