



Safeguarding Adults:

The Role of Health Service Practitioners

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Policy	Estates
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	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	15738
Title	Safeguarding Adults: The role of Health service practitioners
Author	Social Care Policy, DH
Publication Date	14 Mar 2011
Target Audience	Medical Directors, Directors of Nursing, Allied Health Professionals, GPs
Circulation List	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of Nursing, Directors of Adult SSs, Voluntary Organisations/NDPBs, Royal colleges ; Care Quality Commission
Description	This document reminds health service practitioners of their statutory duties to safeguard adults. It aims to assist practitioners in preventing and responding to neglect harm and abuse to patients in the most vulnerable situations. The document provides principles and practice examples that can achieve good outcomes for patients.
Cross Ref	No Secrets Department of Health 2000
Superseded Docs	N/A
Action Required	N/A
Timing	N/A
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For Recipient's Use	

Safeguarding Adults

The role of Health Service Practitioners

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First published March 2011

Published to DH website, in electronic PDF format only.

<http://www.dh.gov.uk/publications>

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Quick Summary:

Section 1: What is 'Safeguarding Adults' and why is it important to delivering health care?

Health services have a duty to safeguard all patients but provide additional measures for patients who are less able to protect themselves from harm or abuse.

'Safeguarding adults' covers a spectrum of activity from prevention through to multi agency responses where harm and abuse occurs. Multi agency procedures apply where there is concern of neglect, harm or abuse to a patient defined under No Secrets guidance as 'vulnerable'.

Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported in law.

Section 2: The safeguarding principles.

Safeguarding adults is shaped by 6 principles:

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

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

Principle 3 – Prevention- Prevention of harm and abuse is a primary objective

Principle 4 – Proportionality – Proportionality and least intrusive response appropriate to the risk presented

Principle 5 – Partnerships - Local solutions through services working with communities

Principle 6 – Accountability - Accountability and transparency in delivering safeguarding

Section 3: Empowering approaches to safeguarding

Duties to empower people to make decisions and be in control of their care and treatment is underpinned by the Human Rights Act 1998, the Equality Act 2010 and the Mental Capacity Act 2005.

- Patients have the right to make choices about their care and treatment – this includes making decisions about their safety, even where those decisions may seem to others to be unwise
- Empowerment is enabling the person to control decisions about their care to the extent they are able.
- Any actions that do not have the person's full and informed consent must have a clear justification, be permissible in law and the least restrictive of the person's rights to meet the justifiable outcome.

Safeguarding Adults: The Role of Health Service Practitioners

- Mental capacity is a key concept in safeguarding and needs to be considered from the outset.
- Person led safeguarding does not override the duty to protect others from harm
- Duty of care involves taking reasonable steps to identify and reduce risk while respecting the person's rights to make choices

Section 4: Safeguarding Adults – What needs to be in place?

Keeping patients safe cannot be effectively managed in isolation. Safeguarding adults needs to be supported through:

1. Working in partnerships

- with patients, carers and others involved in their care
- with partner agencies through multi agency procedures

2. A workforce that sees safeguarding adults as core business. All staff have responsibilities to safeguard adults but some will have specific responsibilities in managing concerns and in multi agency procedures.

3. Integrating safeguarding with patient safety and clinical governance so that

- Individual safeguarding concerns are identified and managed safely
- Practitioners are supported by the service
- The service can understand their safeguarding activity, enable accountability, learning and improvement

Useful resources include:

- Manchester Patient Safety Framework
www.nrls.npsa.nhs.uk/resources/?entryid45=59796
- World Health Organisation patient safety alliance site
www.who.int/patientsafety

Section 5: Responding to concerns – a stepped approach to safeguarding adults

There are key stages in responding to safeguarding related concerns.

- Identify safeguarding concerns
- Make Decisions. Making a reasoned decision about whether to refer through multi agency procedures.
- Multi agency safeguarding responses. Working in partnership to assess, investigate and develop a protection plan.
- Outcomes and learning.

Health services have a key role to play in assessments, investigations and protection planning.

Aides to help:

- Safeguarding principles help guide best practice at each stage in responding to safeguard adults.
- Flowchart for making decisions about referrals - page 29
- Annex 2– flowchart for safeguarding adults and integrated clinical governance + decision making framework – page 48
- Annex 4 – Health focused investigations of neglect - page 55

A range of resources is available at:

www.nmc-uk.org/Nurses-and-midwives/safeguarding/
www.scie.org.uk/adults/safeguarding/index.asp

Section 5: Wider safeguarding – developing a culture for prevention

Prevention of neglect harm and abuse should be a primary objective.

Health services and individual practitioners have a central role in prevention.

- Through working with patients and their carers, helping reduce and manage risks to their safety.
- Preventing neglect, harm and abuse occurring in services by getting the basics right every time through personalised and safe care.

Safeguarding adults involves a culture that prioritises the quality of care, has strong leadership and a competent and safe workforce.

Standards are fundamental to preventing neglect, harm and abuse. Setting standards and measuring how they are used in day to day care, allows services and practitioners to identify concerns about individual patients and early warnings about poor care within their service.

A tool to help services assess and benchmark their safeguarding arrangements can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

Introduction – About this document

This document reiterates the role and duties of frontline health service staff in safeguarding adults. It aims to assist practitioners in their role of preventing and responding to harm and abuse. It supports, No Secrets¹, the statutory guidance for the multi agency partnership in safeguarding adults.

This document is part of a range of materials that the Department of Health and partners are publishing to support No Secrets guidance. Material for health service managers and NHS commissioners are available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

In keeping with Government's approach to decentralisation and local flexibility this document does not prescribe processes or centrally driven targets. It describes how good practice safeguarding principles can guide health services to safeguard adults.

Section 1: What is 'safeguarding adults' and why is it important in delivering healthcare?

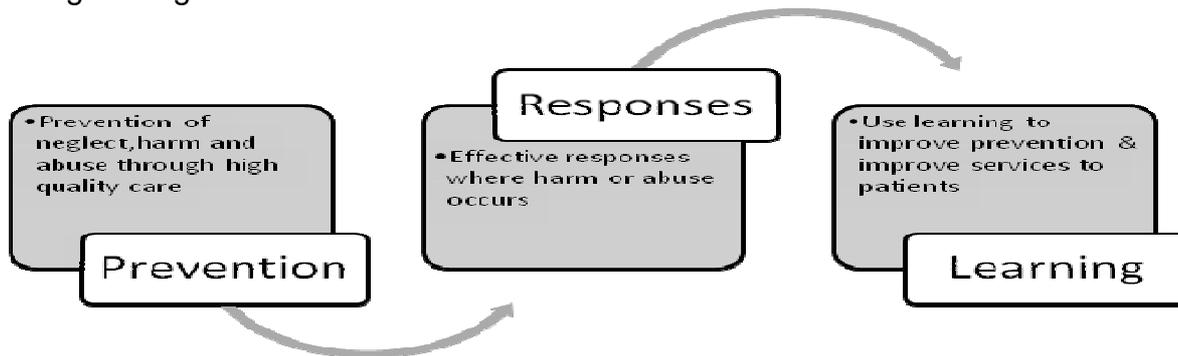
Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well being.

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

¹ No Secrets; Guidance on Developing and Implementing Multi Agency Policies and Procedures to Protect Vulnerable Adults from Abuse; Dept Health 2000

Safeguarding adults includes:



1.1 What are 'safeguarding adults concerns'?

Safeguarding adults concerns vary according to the nature of harm, the circumstances it arose in and the people concerned.



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 and abuse may be physical, sexual, psychological, discriminatory, financial or neglectful in nature. It may involve a single incident or be pervasive across a service.

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.

1.2 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.

Timely assessment will identify adults in the most vulnerable circumstances and use person centred care to reduce the risk of neglect, harm and abuse. Research from the Equality and Human Rights Commission found disabled people are more likely to experience violence or hostility than the wider population and need action to support their safety and security.² Prevention of neglect harm and abuse is discussed further in section 6.

Safeguarding adults multi agency procedures apply where harm or abuse has occurred (or is suspected) to adults currently defined within No Secrets³.

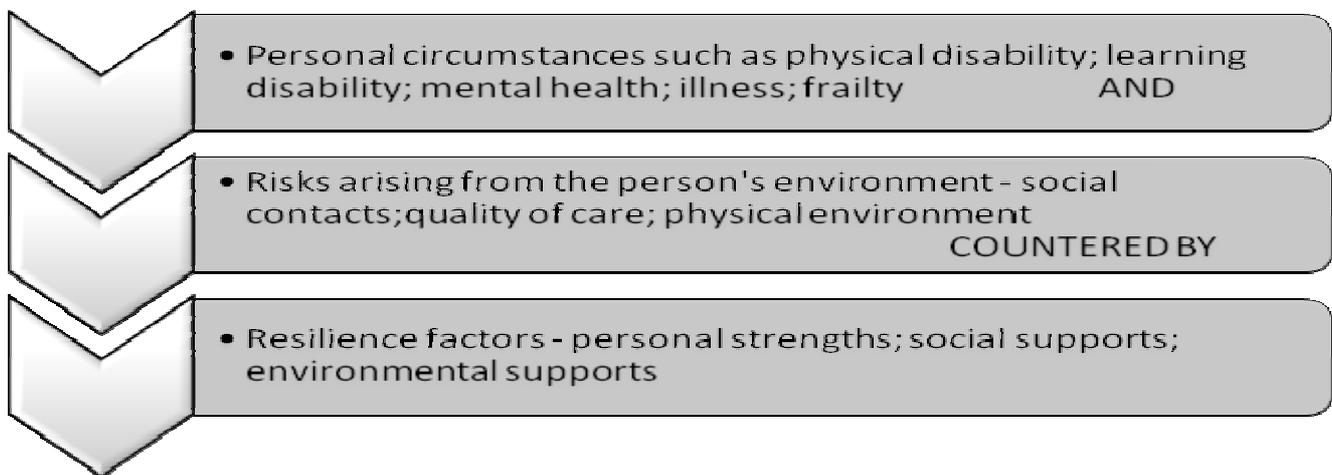
Definitions

No Secrets guidance defines a vulnerable adult as a person:

*“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”.*

A person’s disability or age does not of itself make the person vulnerable.

An adult’s ability to protect himself or herself and safeguard their well being will be affected by:



Applying ‘No Secrets’ definitions within health care settings

Eligibility for social care⁴ (community care services) focuses upon the immediate or longer term risk to a person’s independence and well-being.

² Promoting the safety and security of disabled people; Equality and Human Rights Commission; 2009

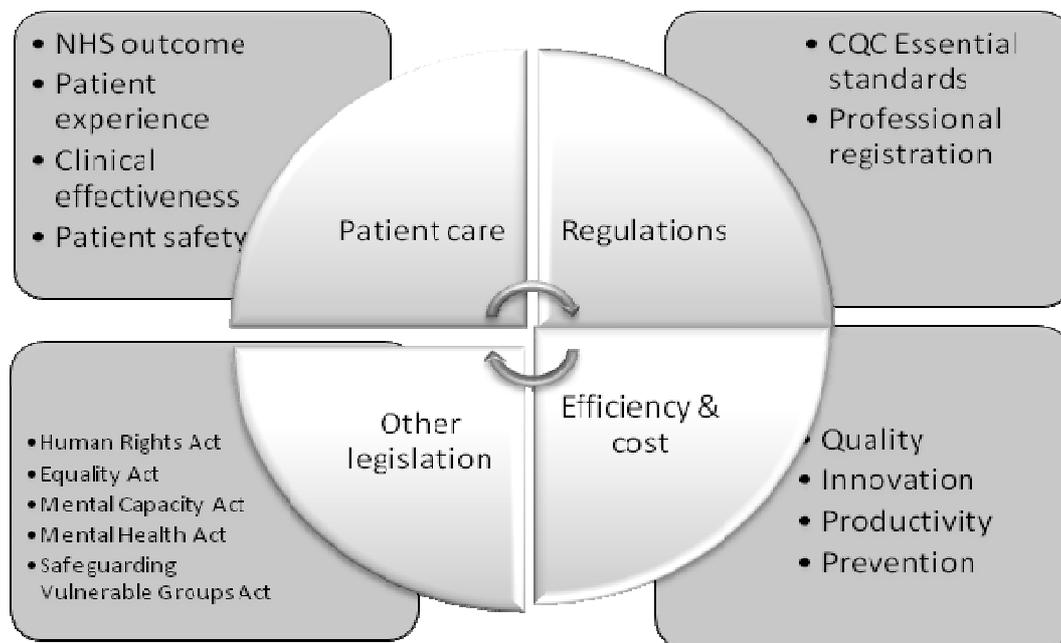
³ No Secrets; Guidance on developing and implementing multi agency policies and procedures to protect vulnerable adults from abuse; Dept Health 2000

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.

1.3 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 NHS. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost effective care.



Learning from high profile inquiries⁵ 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.

4 Prioritising Need in the Context of Putting People First: A whole system approach to eligibility for social care- guidance for eligibility for social care England 2010; Dept Health 2010

5 Care and Compassion; Report of the health Service Ombudsman on ten investigations into NHS care of older people; Parliamentary and Health Service Ombudsman 2011; Mid Staffordshire NHS Foundation Trust Public Inquiry 2010 ; Death By Indifference; No Secrets Consultation Report, Dept Health 2009

- 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 adults 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.

Section 2: The safeguarding principles

The Government 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.

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.

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.

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.

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.

Principle 5 – Partnerships. Local solutions through services working with their communities.

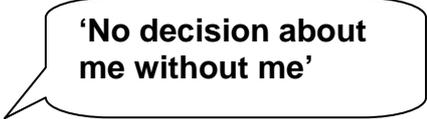
Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

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.

These principles will be referred to throughout this guide.

Section 3: Empowering approaches to safeguarding adults



'No decision about me without me'

3.1 Consent and involvement

An adult's legal right to consent marks the fundamental difference between approaches in safeguarding adults and safeguarding children.

Case law – powers and limitations of the Local Authority in safeguarding adults

'...whatever the extent of a local authority's positive obligations under Article 5, its duties, and more important its powers, are limited. In essence, its duties are threefold: a duty in appropriate circumstances to investigate; a duty in appropriate circumstances to provide supporting services; and a duty in appropriate circumstances to refer the matter to the court. But, and this is a key message, whatever the positive obligations of a local authority under Article 5 may be, they do not clothe it with any power to regulate, control, compel, restrain, confine or coerce. A local authority which seeks to do so must either point to specific statutory authority for what it is doing...or obtain the appropriate sanction of the court....'

Para 96, Re A (Adult) and Re C (Child): A Local Authority v A (2010) EWHC 978 (Fam), Lord Justice Munby

NB Though this statement referred to Local Authorities, the implications are relevant for the roles of public bodies and their role to assist and support rather than to control.

Empowerment involves a proactive approach to seeking consent, maximising the person's involvement in decisions about their care, safety and protection.

Safeguarding Adults: The Role of Health Service Practitioners

It is not possible, nor arguably desirable, to eliminate risk. Empowerment in safeguarding involves risk management that is based on understanding the person, understanding the autonomy of the person and how they view the risks they face. There may be risks the person welcomes because it enhances their quality of life; risks the person is prepared to tolerate and risks they want to eliminate.

An empowering approach in safeguarding involves:



'Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal; and being treated with honesty, respect and dignity.'

'Now I feel tall': What a patient-led NHS feels like (Dept Health, 2005)

3.2 Exceptions. Factors that impact upon a person's rights to control safeguarding decisions.

Three main factors may affect a person's right or ability to make decisions about safeguarding:



3.2.1 Others at Risk of Harm

A patient's right to make choices about their own safety has to be balanced with the rights of others to be safe. This may be a complex task and involves using a human rights based approach to make proportionate decisions that manage competing rights e.g. sharing information without consent to protect others at risk of harm.

Conflict will be minimised where there is an honest approach that gives clear and defensible reasons for any actions taken without consent.

Information sharing: Guidance for Practitioners and Managers⁶ includes seven golden rules for information sharing.

Considering risks to children.

Health services and workers have duties under the Children Act to identify and respond where children may be at risk of harm. Tragedies repeatedly highlight where services have failed to share information about children who may be at risk.

Working Together to Safeguard Children 2010⁷ sets out the roles and duties of agencies to safeguard children. Health workers must consider the implications for children when responding to all safeguarding adults concerns.

For example:

- A person who is causing harm to an adult, may also present a risk to a child
- An adult's parenting capacity may be adversely affected by the stress of abuse they are experiencing
- The choices an adult makes about their own protection may adversely affect their child.

⁶ Information Sharing; Guidance for Managers & Practitioners; HM Government 2008

⁷ Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children; Dept for Education 2010

Staff at all levels of the service need to be competent in safeguarding children so that they can fully consider the needs of children when safeguarding adults.

Practice Example – Safeguarding Children

Susan and her partner are expecting their second baby. Susan has mild learning difficulties and receives additional support from her health visitor.

Susan discloses to her health visitor that her partner has been assaulting her and that it began during her first pregnancy. She doesn't want the relationship to end or any formal action to be taken against her partner.

The Health Visitor recognises that Susan has the capacity to make decisions about relationships. However, she is aware of the physical and emotional risks to the children and their need for support and protection. The health visitor works with Susan to help her weigh up risks and the options for help.

The health visitor supports Susan to make decisions about her own safety but is also clear about her professional responsibilities to protect the children. A referral is made through safeguarding children procedures.

Considering risks to other adults.

Neglect, harm or abuse may also impact on other adults in the environment, for example, other vulnerable adults within the person's home.

Where the concern relates to a care service, there is also a need to consider others who may be at risk within that service and responsibilities to notify regulators. This is reviewed further in section 5.

Practice Example – Concerns about care services

A resident complains to her Continuing Health Care assessor about the standard of care in a nursing home. Though the resident wanted her concerns kept in confidence, the CHC assessor needs to act on the information as other residents may be at risk from poor services.

On initial investigation, some serious concerns come to light. Commissioners and regulators carry out an investigation under safeguarding adults procedures. They share concerns with residents though keep the source of the information in confidence. Commissioners ask residents their views about the quality of care and involve them in the plans for improvement.

By being aware of what care they should expect, residents are able to make an informed choice about whether to remain at the care home or seek alternative care.

3.2.2 Public Interests and Legal Restrictions

There may be other circumstances where the seriousness of the situation involves acting without the consent of a person *with* mental capacity. The legitimacy of this action must be clearly defined, be proportionate to the circumstances and permissible in law.

Management of high risk of serious harm or homicide.

Sharing information should be done with consent where possible. However this may be done without consent where the seriousness of the risk is such that there is a public interest in sharing information in order to prevent a crime or to protect others from harm.

- Multi Agency Public Protection Arrangements (MAPPA) is a statutory process for sharing information about people who present the highest levels of risk to their communities.
- Multi Agency Risk Assessment Conference (MARAC) responds in situations of domestic violence where there is high risk of harm or homicide. The patient's consent to share information should be sought unless there is compelling reason not to e.g. it may put them at a greater degree of risk.

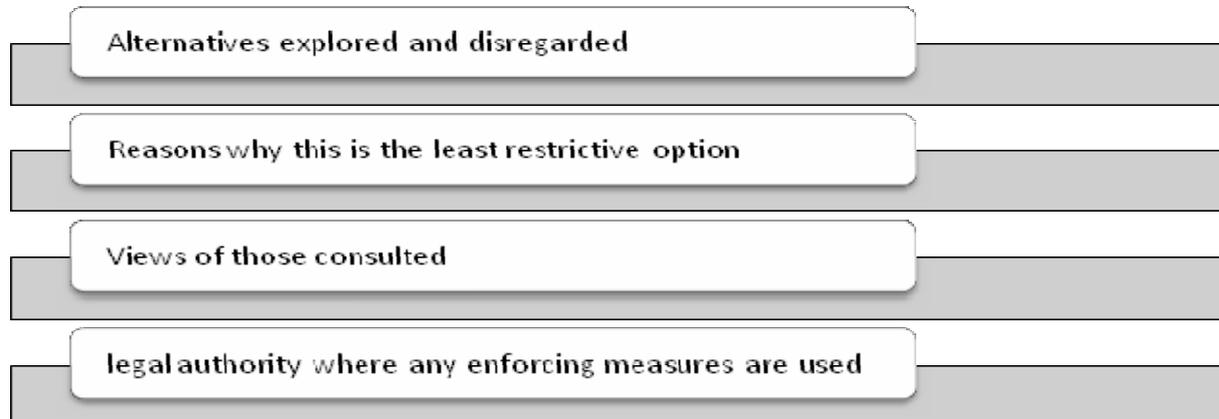
Legal Restrictions

There may be exceptional circumstances where a patient who has capacity, makes a decision or intends to act in a way that brings civil or criminal law into play. Examples include

- Where their action or intended course of action is unlawful
- Where their care may need to be addressed under the Mental Health Act 1983
- Where other legislation such as the Environmental Protection Act 1990, may be relevant.

Management of such complex situations is likely to include others such as legal services and members of the multi disciplinary/interagency team in exploring the best way forward. Ultimately, where no alternative solutions can be found, legislation may need to be used in the interests of the person or to protect the rights of others.

Recording should demonstrate defensible decisions:



Practice Example – use of the Mental Health Act 1983

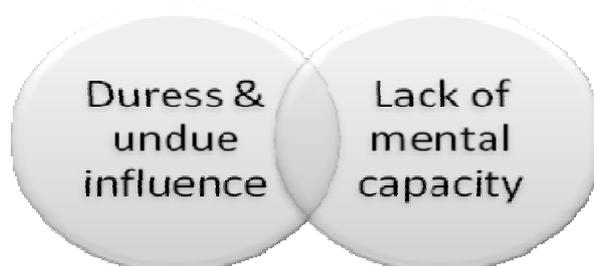
Maria lives alone and has bi-polar affective disorder. When unwell, Maria can be disinhibited and very vulnerable to sexual and financial exploitation. This causes her severe distress when she recovers her mental health.

Maria works with her community mental health nurse to plan how to minimise these risks. On occasion, the Mental Health Act has been used to provide Maria with treatment for her bi-polar illness. This followed careful consideration of alternative, less intrusive ways of managing risk.

Treatment restores Marie's mental health and ability to make decisions for herself.

3.2.3 Mental capacity and impaired decision making

A person's ability to make a particular decision may be affected by:



There may be a fine distinction between a person who lacks the mental capacity to make a particular decision and a person whose ability to make a decision is impaired e.g. by duress or undue influence. Nonetheless, it is an important distinction to make.



Fundamentals

People may need additional support to make decisions

Where a person lacks mental capacity for a particular decision, the Mental Capacity Act provides the authority to make a best interests decision without consent.

Duress and coercion may affect a person's judgement and ability to make a decision but there remains a presumption of capacity. The person retains the right to make decisions but may need more support to exercise these rights.

Lack of Mental Capacity for the Relevant Decision

Mental capacity is a key legal concept in responding to safeguarding adults concerns.

The Mental Capacity Act 2005 provides the statutory framework that underpins issues relating to capacity and protects the rights of people where capacity may be in question. It is therefore integral to safeguarding adults.

Further information can be found at

<http://www.dh.gov.uk/en/SocialCare/Deliveringsocialcare/MentalCapacity/MentalCapacityAct2005/index.htm>

The 5 statutory principles of the Mental Capacity Act are directly applicable to safeguarding and are summarised below.

- 1. A person must be assumed to have capacity unless it is established that he lacks capacity.**
Assumptions should not be made that a person lacks capacity merely because they appear to be vulnerable.
- 2. A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success**
Empower patients to make decisions about managing risks e.g. use communication aides to assist someone to make decisions; choose the optimum time of day where a person with dementia may best be able to evaluate risks.
- 3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision**

Patients will wish to balance their safety with other qualities of life such as independence and family life. This may lead them to make choices about their safety that others may deem to be unwise but they have the right to make those choices.

4. **An act, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests**

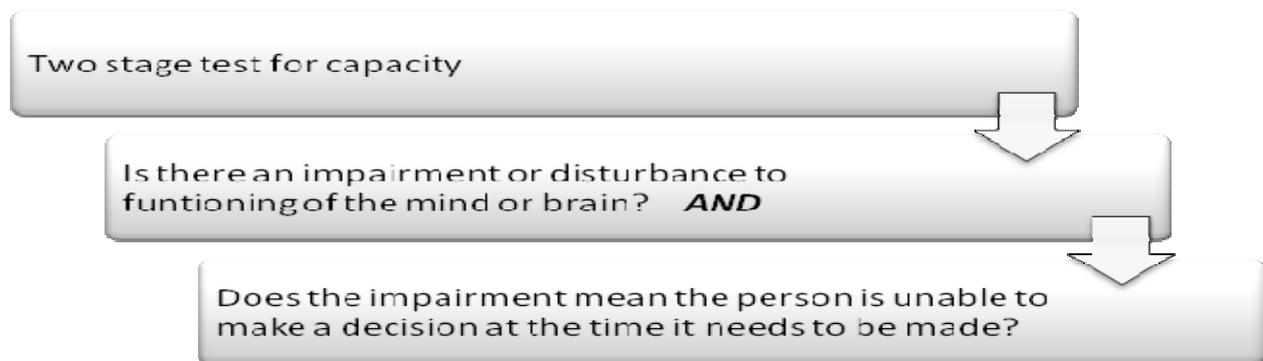
Best interests decisions in safeguarding take account of all relevant factors including the views of the patient, their values, lifestyle and beliefs and the views of others involved in their care.

5. **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.**

Where a person lacks capacity to make a decision, any use of restriction and restraint must be necessary and proportionate and to prevent harm to that person. Safeguarding interventions need to balance the wish to protect the patient from harm with protecting other rights such as right to family life.

Assessing Capacity & Best Interests

Assessment of capacity is through:



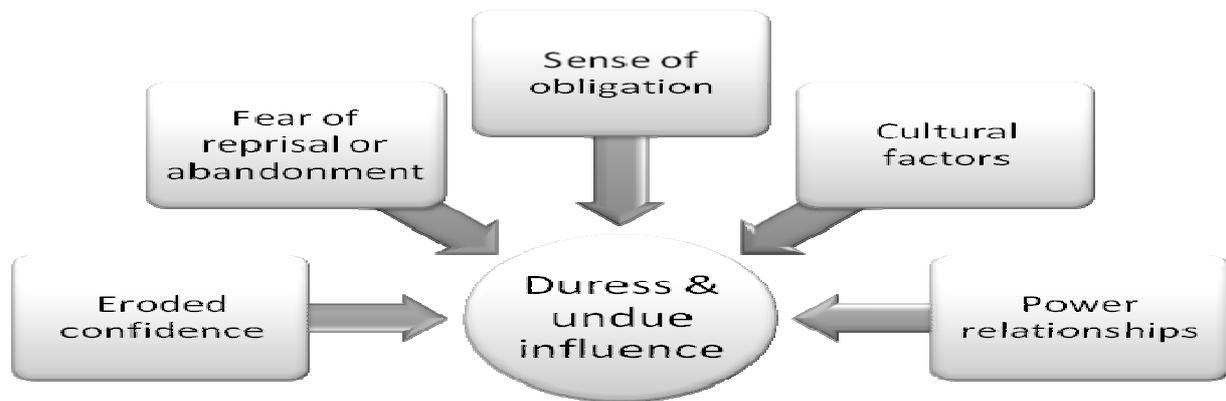
A person may have capacity for one type of decision but lack capacity for a more complex decision. Similarly a person's capacity may fluctuate – a person may temporarily lose capacity for some decisions e.g. due to a mental health need or during post-operative recovery.

Where a patient is unable to make a particular decision, individuals still have a duty to involve the person but will make decisions based on their best interests.⁸

⁸ Mental Capacity Act 2005; Code of practice; Dept Constitutional Affairs; 2007

Impaired decisions based on duress and undue influence

A person, who has mental capacity to make decisions, may have their ability to give free and true consent impaired, if they are under constraint, coercion or undue influence.



Though this may affect a person's ability to make decisions, it does not remove the rights of the person to make decisions. Nor does it provide any authority to over ride the person's wishes. The role of services is to support the person to make decisions and take positive action to prevent or stop another individual from interfering with their rights.

Some situations may involve a criminal act and involve the police. In other circumstances, the High Court could be approached to exercise inherent jurisdiction.

Principle 1 – Empowerment. Presumption of person led decisions and consent

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

Principle 4 – Proportionality. Proportionality and least intrusive response appropriate to the risk presented

3.3 What about duty of care to the patient?

Practitioners may find it difficult to accept the patient's choices – declining services or acting against advice about how to manage their safety.

Practitioners may be concerned that they are failing in their duty of care and that they could be found to be reckless or negligent.

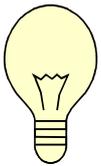
A duty of care is a requirement placed on an individual to exercise a reasonable standard of care while undertaking activities (or omissions) that could foresee ably harm others. However, duty of care also includes respecting the person's wishes and protecting and respecting their rights.

The Health Professions Council standards state⁹

‘...a person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure they are fully aware of the risk of refusing treatment, particularly if you think there is a significant or immediate risk to life.’

Duty of care can be said to have reasonably been met where an objective group of professional considers.¹⁰

- All reasonable steps have been taken
- Reliable assessment methods have been used
- Information has been collated and thoroughly evaluated
- Decisions are recorded, communicated and thoroughly evaluated
- Policies and procedures have been followed
- Practitioners and their managers adopt an investigative approach and are proactive



Remember the basics

- Empowerment is a foundation block for all safeguarding
- Empowerment means maximising the patient's involvement
- Patients are presumed to have capacity
- Any actions taken on a patient's behalf require their full and informed consent.
- Any action without consent must be clearly justified and permitted in law
- Where a patient cannot lead decisions, they should still be involved to the maximum the circumstances allow
- Patients have the right to choose how to manage their safety – even where this may involve risk
- A patient's choices cannot compromise duties to protect others

⁹ Health Professions Council Standards of Conduct Performance & Ethics; 2008

¹⁰ Kemshall, H. (2009) Quoted in Nothing Ventured, Nothing Gained Dept Health 2010

Section 4: Safeguarding Adults - What needs to be in place?

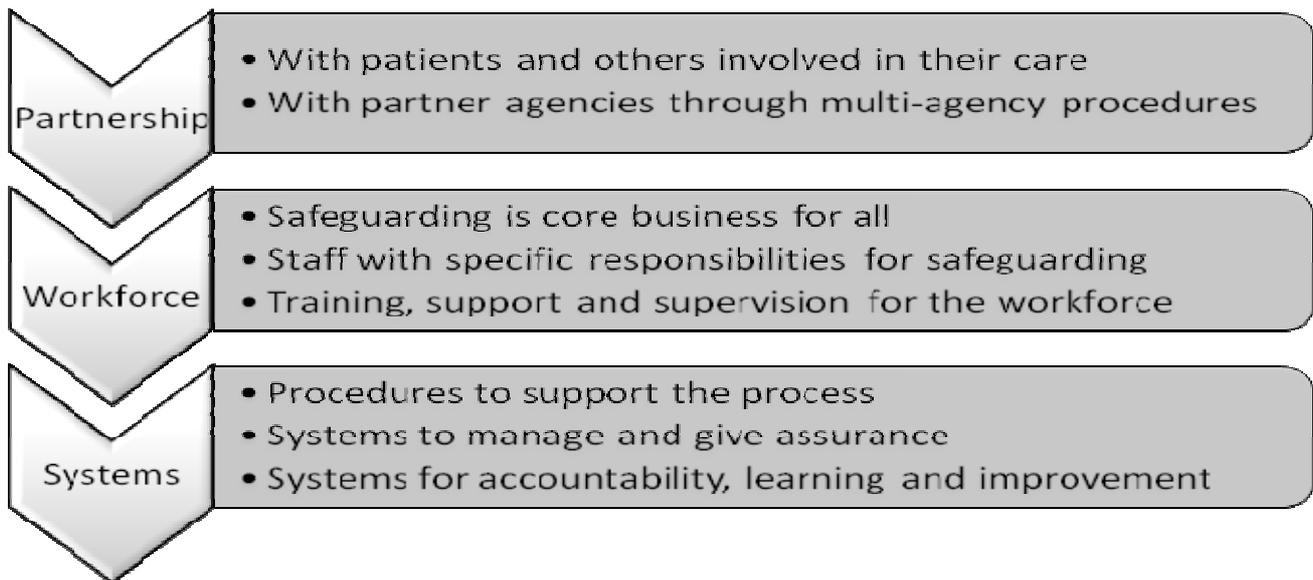
Frontline staff cannot manage safeguarding adults concerns effectively in isolation from their service or from the safeguarding partnership.

Safeguarding adults will be most effective where it is part of patient care, managed within the service through strong leadership.

Material suggesting approaches for health service managers and NHS commissioners along with a self-assessment framework are available at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

This section outlines three key components that will support good outcomes for patients.



4.1 Working in Partnerships

Principle 5 – Partnerships.

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

The Local Authority is the lead agency for safeguarding adults. They coordinate the local Safeguarding Adults Board, a multi agency partnership responsible for leading all safeguarding adults work.

Safeguarding Adults: The Role of Health Service Practitioners

Responses to safeguarding adults referrals are coordinated by the local safeguarding adults service. Multi agency procedures set out the roles and responsibilities of staff within the service and within partner agencies.

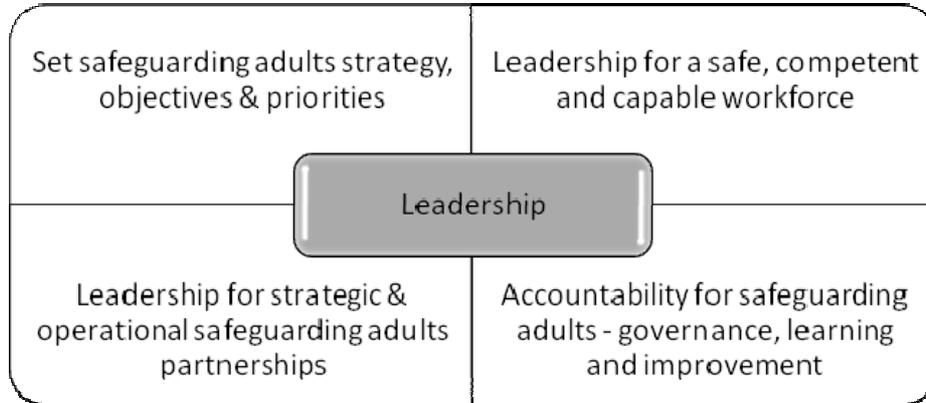
Good working partnerships are based on:



A national framework for the safeguarding partnership was produced in 2005.¹¹

4.2 A workforce that safeguards patients.

Safeguarding adults requires strong leadership to lead this partnership and a workforce that sees safeguarding as core business.



Local services will determine their workforce plan for safeguarding. The structure, capacity and designation of this workforce, will depend upon the size, structure, and complexity of the service and the skills and competence of staff.

These different responsibilities call for a range of learning and development opportunities to support them e.g. supervision; single and multi agency training; generic and specialist training programmes.

¹¹ A National Framework of Standards for Good Practice and Outcomes in Adult Protection; ADASS 2005

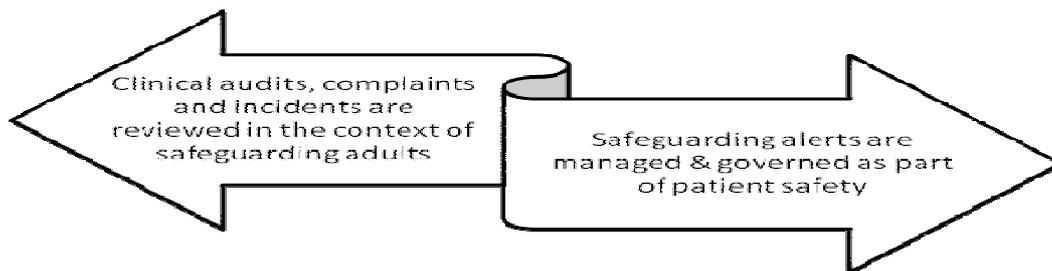
Annex 1 provides examples of the core functions needed by the workforce to safeguard patients and considers learning and development to support the roles

4.3 Using the service's systems to safeguard adults.

Where safeguarding is managed as part of the service's wider systems for patient safety and governance:

- There is safe management of individual concerns– for example, procedures about how safeguarding concerns are communicated, recorded and acted upon.
- Staff are supported by the service in carrying out their duties
- The service can be accountable for its safeguarding activity – identify patterns and trends; assure the quality of responses to concerns; judge outcomes and target improvements.

Principle 6 – Accountability and transparency in delivering safeguarding



This integrated approach is supported by the national patient safety framework for investigating serious incidents.¹² This framework defines allegations of abuse as serious incidents to be investigated through local safeguarding adults procedures.

Annex 2 provides a flowchart for this integrated process.

Having clear internal safeguarding adults procedures will guide the workforce and support the service in managing safeguarding adults.

Annex 3 provides a checklist as an aide for developing internal procedures

Other useful resources include:

- Manchester Patient Safety Framework www.nrls.npsa.nhs.uk/resources/?entry45=576
- World Health Organisation patient safety alliance site www.who.int/patientsafety

¹²The National Framework for Reporting and Learning from Serious Incidents Requiring Investigation; National Patient Safety Agency 2010

Practice Example

University Hospitals Birmingham Chief Nurse leads their 'Root Cause Analysis of Clinical Care' group. Data relating to serious incidents, complaints, safeguarding adults referrals are reviewed to identify emerging themes, trends and learning.

The group assure learning has led to change through a detailed quarterly assurance review. Information from this group feeds into a higher level 'Care Quality Group' that develops the Trusts work on areas such as patient experience, equality, dignity in care and high impact interventions. This group is chaired by the Chief Nurse and include non-executives and governors.

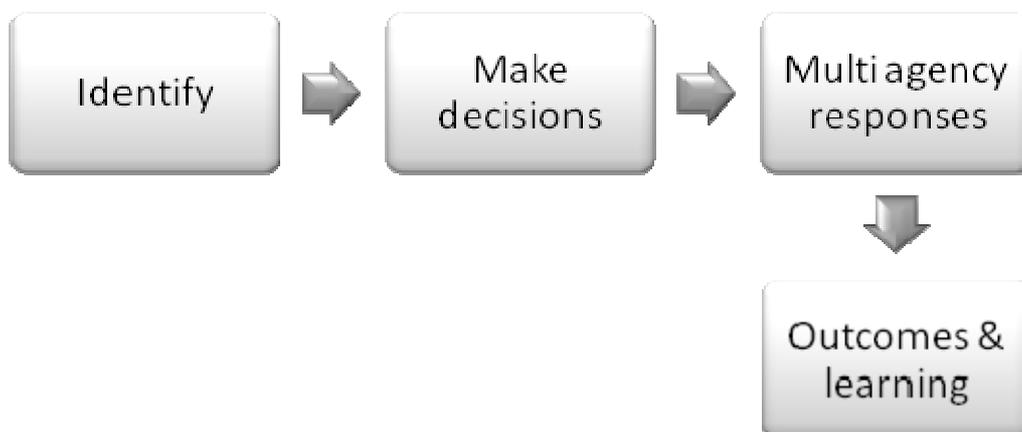
Learning has led to initiatives such as 'Ability, Not Disability' toolkits to assist in reasonable adjustments and communications.

Section 5: Responding to concerns - A stepped approach to safeguarding adults.

Local multi agency procedures and protocols will detail the role and responsibilities for staff and agencies from first identification of a concern through to evaluating the outcome.

This section does not prescribe detailed responses but considers the role of Health across the safeguarding pathway and how the safeguarding principles can guide good outcomes.

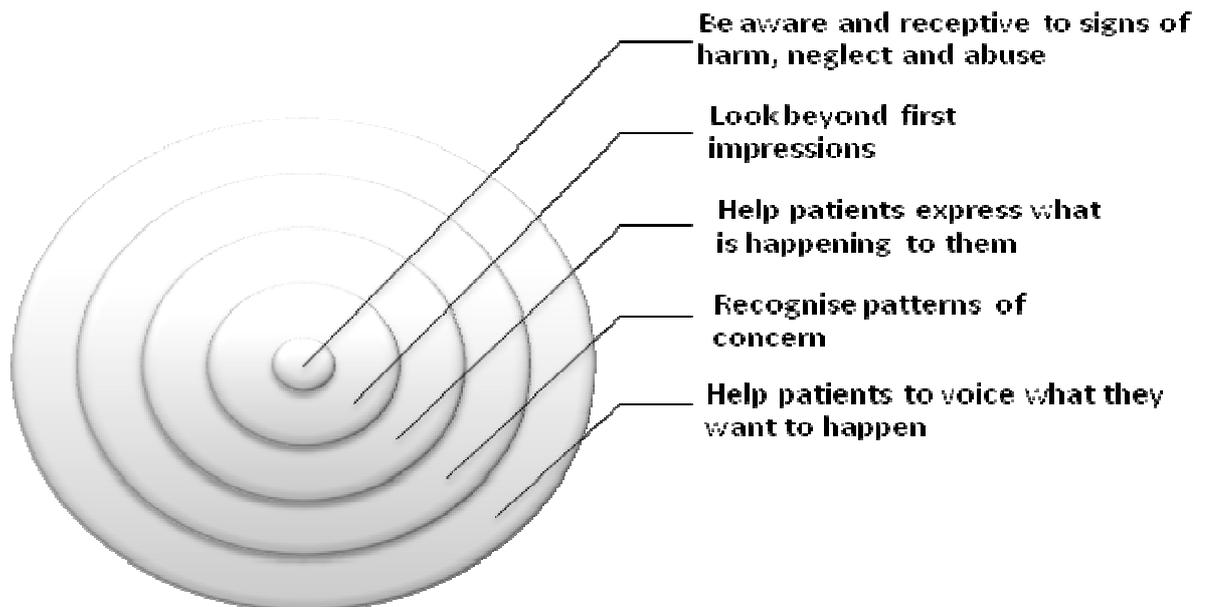
The safeguarding adults pathway:



Identify

5.1 Step 1

Health staff, may be uniquely placed to identify a possible safeguarding concern - a district nurse may suspect a neighbour is financially exploiting a patient; an occupational therapy student observes neglectful practices on a ward.



Services that see safeguarding adults as their core business have a culture where all staff know it is *their* responsibility to act. Staff are confident in supporting the patient. They take responsibility for immediate safety, they know about recording and preserving evidence and how to raise an alert within their service

Make decisions

5.2 Step 2

Making decisions about when to refer through multi agency procedures can be complex. The size of the service and the skills of their staff will determine who makes these decisions e.g. qualified staff, senior clinicians; team managers.

Section 2 reviewed the principles of empowerment and the circumstances when there may be a duty to act without consent. This is a key factor where the concern relates to a regulated services or staff within them.

Making Decisions where concerns relate to services

When a concern relates to a regulated service, there is responsibility to consider risks to others within that care setting. It also brings responsibility related to compliance with the CQC registration requirements and the regulation of individual workers.

Providers of that service have particular responsibilities to address failures in care. Commissioners and regulators need to be assured that concerns are acted upon.

As identified in section 4, safeguarding adults needs to be integrated with clinical incidents, using the national patient safety framework for serious incidents to investigate neglect and abuse through local multi agency procedures.¹³

Aides for Decision Making.

- Use the partnership. Decisions will be easiest where there are clear protocols and procedures. Good relationships allow staff to pick up a phone and talk through an issue with their local safeguarding service.
- Figure 1 highlights main factors that those making decisions should take into account.
- Annex 2 provides a flow chart and decision making framework to aide integrating safeguarding with clinical governance and making decisions about when to refer through multi agency procedures.
- Use the safeguarding principles to guide decision making

Making Decisions and the safeguarding principles

Empowerment – What does the person want? What rights need to be respected? Are there duties to act – are others at risk of harm?

Protection – Is this person a ‘vulnerable adult’? What support do they need? Is capacity an issue? Should others such as a carer be involved?

Proportionality – Have risks been weighed up? Does the nature of the concern require referral through multi agency procedures?

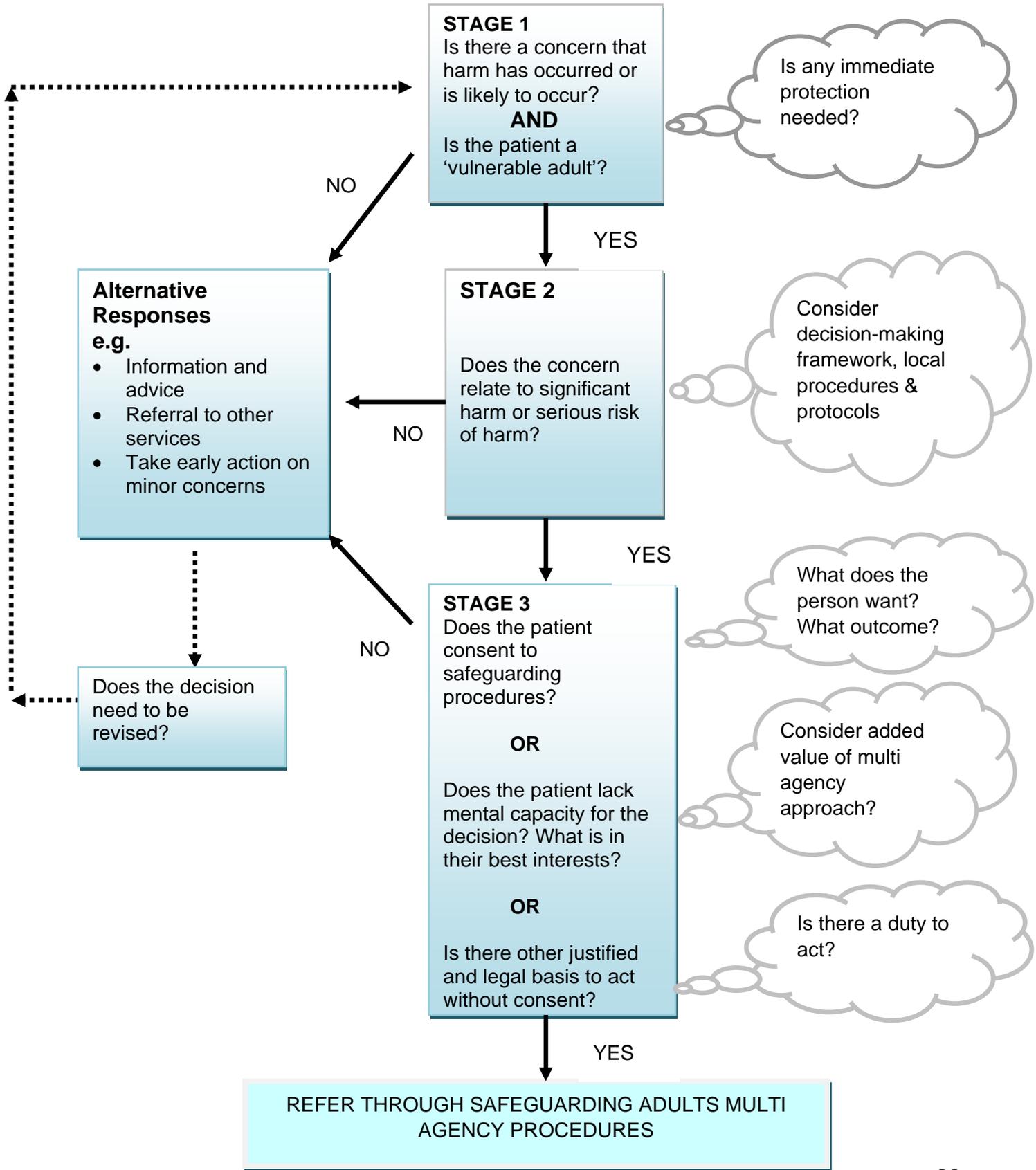
Partnership – What is the view of others involved? How do multi agency procedures apply?

Accountability – Is the decision well made? Is it defensible?

13 National Framework for Reporting and Learning From Serious Incidents Requiring investigation; National Patient Safety Agency 2009

Figure 1: Safeguarding Adults Decision Making

THINK 
 How do the safeguarding principles apply?



Referral to the Police

Some incidents may require police involvement. Where referrals are made to local safeguarding adults service, multi agency procedures will indicate when and how police are involved along with recording and retaining evidence.

The safeguarding principles relating to consent and duty to act, also apply in decisions about referral to police. Involvement of police is indicated in incidents of suspected theft, common assault (including sexual assault), assault causing actual bodily harm. However, police may also be involved in other patient safety incidents such as wilful neglect for a person lacking capacity.

A protocol has been developed between the Department of Health, the Association of Chief Police Officers and the Health and Safety Executive to guide on their involvement in patient safety incidents.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4129918

Within the protocol, the types of patient safety incident that may prompt a healthcare provider to involve the police are where there is:

- Evidence or suspicion that the actions leading to harm were intended
- Evidence or suspicion that the adverse consequences were intended
- Evidence or suspicion of gross negligence and/or recklessness in a serious safety incident

Decisions not to make a referral through safeguarding adult procedures

There may be many valid reasons not to refer on through multi agency procedures. The reasons should be well documented along with the alternative care plan.

Practice Example 1.

Doreen regularly visits her GP for help in managing her schizophrenia. During a visit, she tells her GP that her son recently hit her – she's not sure what she wants to do. The GP helps Doreen to think about what she wants to happen, the help she could receive and how multi agency safeguarding procedures could help.

Doreen decides that at this stage she doesn't want others involved but accepts advice and information from the GP about what she could do. The GP confirms that Doreen has capacity to make this decision and that no-one else, including children are at risk of harm.

A follow up appointment is made with the agreement that Doreen can attend earlier if she needs to. With Doreen's agreement, the GP records this in her healthcare record with a 'flag' to highlight the concern for the primary care team. This allows the team to be alert and respond quickly if Doreen changes her mind or in the event of the risk worsening.

Practice Example 2

A relative of a care home resident complained that neither of her mother's key workers could speak English or understand what her mother was saying. She was concerned that her Mother was being neglected because of the language barrier.

The resident's care was reviewed. No harm had occurred and no referral was made through local safeguarding adults procedures.

However the complaint was an early warning. It highlighted that the resident had not been involved in her care and other residents may be similarly affected.

The care home manager revised the allocated key worker arrangements for the resident. She used Essence of Care 2010 benchmarks for communication to consider how to meet individual communication needs of all residents. Carers and family members were involved in building communication needs into care plans. The manager audited the staff skills in communication and developed plans to improve communication and culturally responsive care for all the residents.

Practice Example 3

A patient with high dependency needs related to an acquired brain injury has an appendectomy. Following the operation, it is discovered that a swab has been left in the wound. A serious incident is raised. Consideration is given to referring through safeguarding adults procedures as the patient may fall within safeguarding adults definitions.

The view is that the patient's impaired ability to protect himself was coincidental to the incident i.e. the patient's brain injury was not a factor in the quality of care they received. This was an isolated incident and required investigation as a serious incident but referral through safeguarding adults procedures is not required.

Given the seriousness of the situation, and to ensure openness and transparency, the 'decision maker' discusses this with the Local Safeguarding Adults Service. They agree the a referral will not be made through safeguarding adults procedures but would be investigated by the service as a serious incident. This decision would be kept under review as information became known during the serious incident investigation.

An advocate supports the patient through the serious incident investigation process.

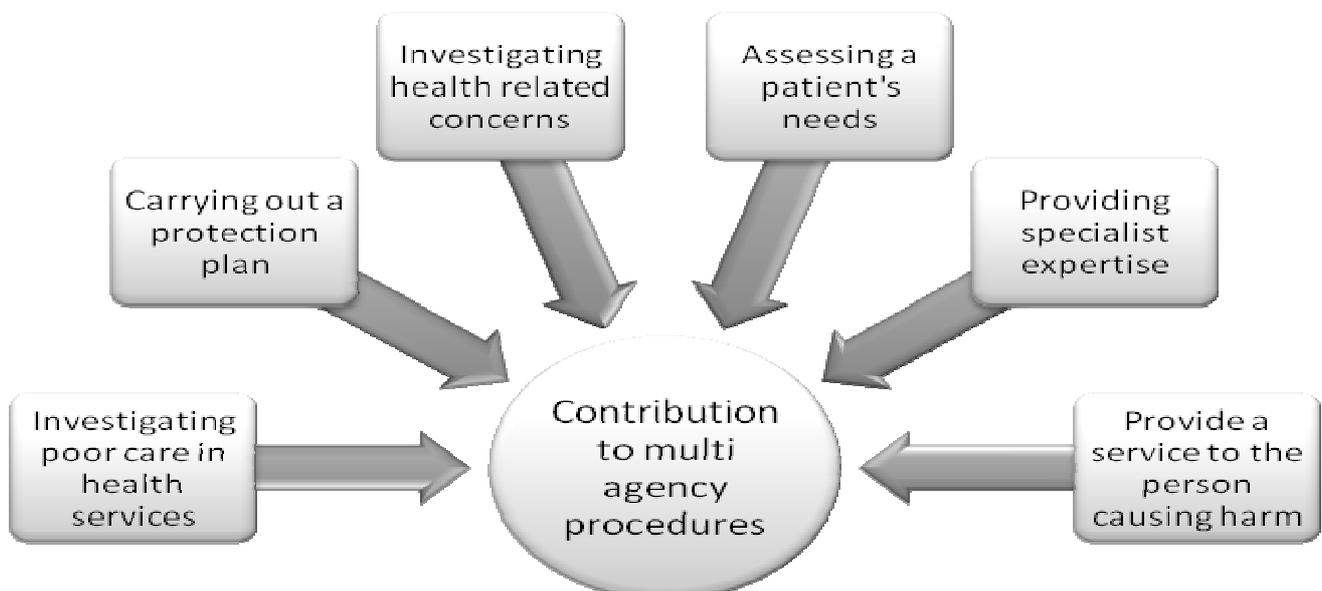
Multi agency responses

5.3 Step 3

Where a referral is made to the local safeguarding adults service, multi agency procedures will detail the process for responding and the roles and responsibilities of each partner.

Example of Multi Agency Pathway:	
Referral decision	What is the nature of the concern? Should it be managed through multi agency procedures?
Strategy	What is the outcome sought by the patient and others? How can this best be achieved in an effective and culturally competent way? What level of response is required? Planning – who, what, when, how?
Assessment and Investigation	Assessment and addressing the patient’s individual needs, age, lifestyle, wishes and beliefs. Investigating the concern
Protection plan	Planning with or on behalf of the person Protection for others at risk of harm Responses/support to address the cause of the harm or abuse
Review and evaluate	Evaluate the outcome. Further steps for recovery Learning and improvements

Health services are important partners in these multi agency responses:



Practice Examples – Involvement in the multi agency response.

A nurse carries out an investigation to understand whether neglect of Mr Ali led to his poor health condition

A pharmacist provides expert advice relating to alleged abuse of medication.

A tissue viability nurse assesses whether reasonable care has been taken in avoiding and treating a pressure ulcer.

A Doctor provides assessment and care through the Sexual Assault Referral Centre

A dementia care specialist works with Mrs Lee and her family, providing therapeutic care following an incident of abuse

A mental health practitioner provides drug & alcohol services to help Adam, Mr Jacob's son who has been financially exploiting his father.

A GP reviews with his patient, Mrs Mathews, whether her protection plan is working.

Investigations involving regulated services.

Where there is a concern about neglect, harm or abuse in health services, providers, commissioners and regulators all have roles to play in the investigation.

Providers have specific responsibilities to address the concerns and refer to regulatory or professional bodies where required.

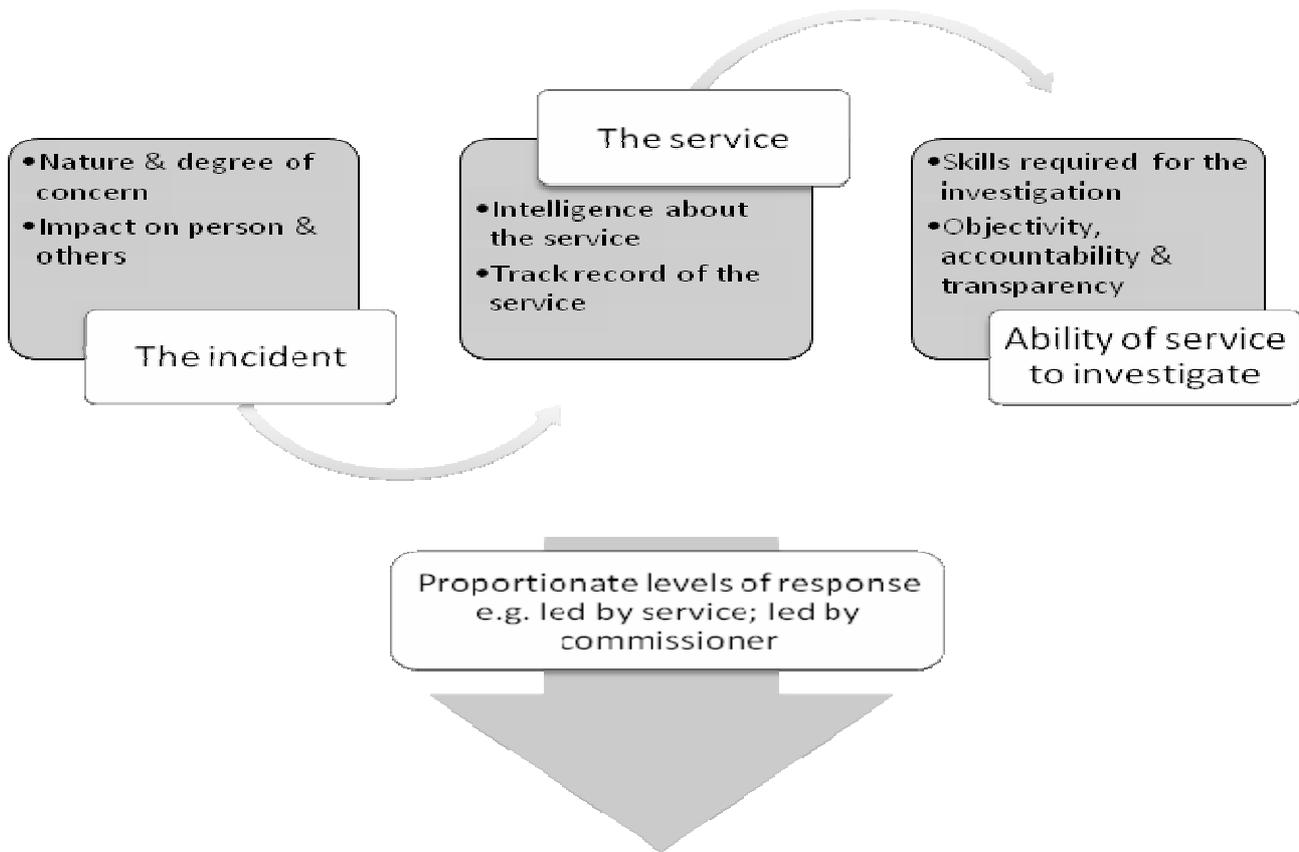
Commissioners and regulators also have responsibilities for monitoring the quality of care and assuring that providers address the concerns. The Care Quality Commission takes a role where the safeguarding concern arises within a regulated service. The CQC safeguarding protocol¹⁴ sets out its role as regulator.

The local multi agency procedures should detail the roles and responsibilities between the local safeguarding adults service, the provider, commissioner and regulator.

Sharing information between these bodies is an important means of reaching a measured assessment about the level of concern and a proportionate decision about the best way to investigate.

¹⁴ Care Quality Commission; Our Safeguarding Protocol; The Care Quality Commission's Commitment to safeguarding

Assessing risk and deciding the levels of response needs to consider:



Aides for involvement in multi agency procedures:

- Staff involved in investigations and protection planning will be guided through multi agency procedures and their service's procedures.
- Staff should also be able to access supervision and training to support their role. Annex 1 provides examples of the core functions of the safeguarding workforce and learning and development to support the roles
- Tools developed by the National Patient Safety Agency are available at www.nrls.npsa.nhs.uk/resources to help services investigate and analyse incidents e.g. root cause analysis toolkit; five whys technique; fish bone analysis template.
- Annex 4 provides guidance on health focused investigations
- Use the safeguarding principles to guide investigations and protection planning

Multi agency responses & the safeguarding principles

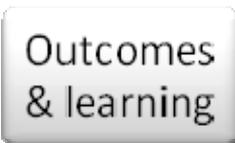
Empowerment: Involvement in assessment and protection plan – what outcome does the patient want? What additional measures are needed to involve the person and provide culturally competent responses?

Protection: Does the patient need representation – advocate/IMCA, carer?

Proportionality: What is the least intrusive way of investigating?
Are investigations proportionate to the risk?
Is the protection plan the least restrictive way of managing risks?

Partnership: Who should be involved in the investigation and protection plan?

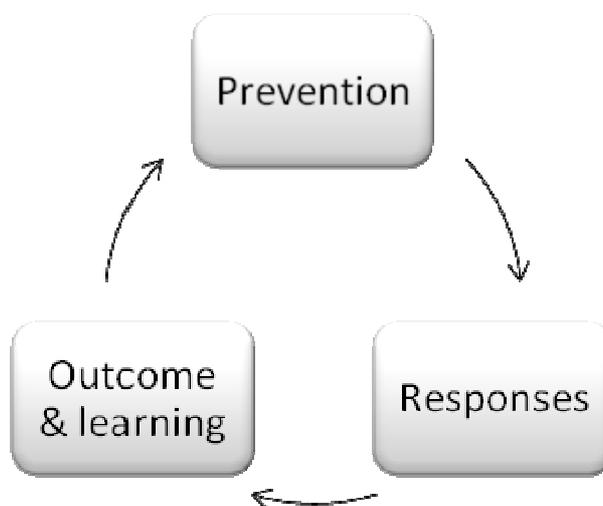
Accountability: Does the patient know who is doing what, by when and to what outcome? Is the investigation and protection plan justifiable? Is it clear what went wrong and what's being done to put it right?



5.4 Step 4

Whenever a safeguarding incident arises, there is opportunity for learning

- Understand how well the incident was managed and whether the patient's outcomes were met.
- Use information to understand wider themes and trends and improve prevention.



Practice Examples – Outcomes and Learning.

A mental health trust routinely sought feedback from users and, where appropriate, their carers, about how well safeguarding concerns had been managed. They reviewed how well the person was involved and whether their situation had improved as a result. The learning was used in training and to improve guidance.

A Community Team for Learning Disabilities noted a high percentage of their safeguarding adults referrals related to financial abuse. They worked with their safeguarding partners including the police, to tackle the cause. The team worked with individual service users to help raise their awareness of financial abuse and used 'stay safe' plans to help reduce risks of further abuse.

A Care Home provider identified that one care home for dementia care had a high rate of reported safeguarding concerns where another similar home had very low rates. They investigated further to understand whether this was due to under or over reporting or whether it indicated a recurrent concern about care.

Serious Case Reviews

Local arrangements will determine when a serious case review should be undertaken. This may be where there has been a death related to abuse or where there are serious concerns about how agencies have worked together.

Health services may be asked to contribute individual reports about their role, so that good practice and areas for improvement can be highlighted.

The serious case review is an important mechanism for accountability and transparency within the service, to patients and public and to the multi agency partnership. Importantly, it provides the opportunity for detailed learning that can be used across the multi agency partnership to improve outcomes for patients.

Aides for Outcome and Learning

- Tools developed by The National Patient Safety Agency (NPSA) help services to find solutions to address root causes.
- NPSA also provide tools to help services learn lessons from how an investigation was undertaken. www.nrls.npsa.nhs.uk/resources
- Remember the principles

Outcomes and learning & the safeguarding principles.

Accountability.

- Recognise good practice as well as individual, service or systems failures
- Make action plans, clear and measurable - be clear about how plans will be implemented and how improved outcomes will be demonstrated.

Prevention

- Use learning for the service and the partnership to understand learn and improve prevention

Section 6: Wider safeguarding – developing a culture for prevention.

Preventing neglect harm and abuse is a primary objective.

Health services and individual practitioners have a central role in prevention.

- Working with patients and their carers, helping them to reduce risks to their safety.
- Preventing neglect, harm and abuse occurring within health services.

Research from the Equality and Human Rights Commission found disabled people are more likely to experience violence or hostility than the wider population and need action to support their safety and security.¹⁵

6.1 Prevention through direct work with patients and their carers

Preventing harm and abuse involves helping patients consider potential sources of risk and how they might be managed. What does 'risk' mean for them? How does risk relate to their age, impairment, lifestyle, beliefs and culture? Are there potential benefits as well as disadvantages of taking risks?

¹⁵ <http://www.equalityhumanrights.com/key-projects/good-relations/safety-and-security-for-disabled-people/>

'People who wander may never become lost and those who never wander may become lost' (Rowe et al, 2004)

Nothing Ventured Nothing Gained; Guidance for People with Dementia; DH 2010

The Mental Capacity Act enables patients to plan ahead and manage risks at a future point where they have lost capacity. A Lasting Power of Attorney can be an important mechanism to manage decisions about welfare and finance, reducing risks for example, of financial exploitation.

Prevention is also about working in partnership with carers, using their expertise to understand and address risks to patients.¹⁶ Supporting carers reduces risks of unintentional harm or neglect, where carers are left without the means or ability to provide adequate care.

Practice Example

- Davika has mental health needs and has lived in supported care for many years. Davika is due to move into her own tenancy. Davika and her family are concerned that she may be harassed or exploited by some local teenagers.

Davika's community nurse works with her and her family to help her manage these risks. They use her Care Programme to record the plan, detailing what she can do and who she can contact for help.

Wokingham Borough, Safer Places Scheme was set up to help people who are feeling vulnerable or scared when they are out and about in Wokingham. Green 'safer places' stickers are used to show places such as shops/public buildings where staff will find the person somewhere quiet to sit and phone someone to help them.

Practice Example

- Rashid is due to be admitted to hospital for an operation. He has severe learning disabilities. Rashid's brother is concerned that staff won't take time to communicate with him or to understand how to respond if he becomes distressed. He is particularly worried that this may lead to him not eating or drinking properly or staff resorting to restraint if he becomes distressed.

The Community Team for Learning Disability work with Rashid's brother to develop a 'health passport' for him that gives hospital staff details about the best way to communicate with Rashid and understand his behaviour.

Medway Council Learning Disability team developed 'passports' for people with learning disabilities to ensure that when any person attends for medical care, the clinical staff have written confirmation of the patient's personal needs such as means and style of communication and cultural considerations.

¹⁶ Recognised valued and supported. Next steps for the Carers Strategy; Dept Health 2010

Case Example

Ruby has arthritis and has recently been diagnosed with dementia. Ruby is increasingly reliant on her husband Winston for her personal care. Ruby and Winston don't want others coming to their home as they are worried about 'people taking over'. The GP is aware that Winston has a heart condition and may find his caring role increasingly difficult. Ruby's high dependence means she is at risk of neglect if Winston is unable to care for her.

The GP discusses with the couple the range of supports available. They agree to talk to a care manager and have a carer's assessment. The couple use a direct payment for assistive technology and flexible home care to give Winston a carer's break when needed. The GP sets regular appointments for the couple and Ruby makes Winston a Lasting Power of Attorney for her welfare and finance.

6.2 Preventing neglect, harm and abuse within health services

Prevention in services is about getting the basics right every time through personalised and safe care.

There are known factors associated with institutional abuse¹⁷.

- A closed inward looking culture and weak management at ward and locality level
- A poor institutionalised environment
- Low staffing levels
- High use of bank staff
- Little staff development
- Poor supervision.

Within such environments patients can become de-humanised and neglect and abuse can grow unrecognised or unchallenged.

Risks of neglect harm and abuse will be reduced where there is strong leadership and a shared value base where:



¹⁷ Commission for Health Inspection report Rowan Ward Manchester Health and Social Care Trust 2002

The National Quality Board reviewed factors promoting safety in high risk systems.

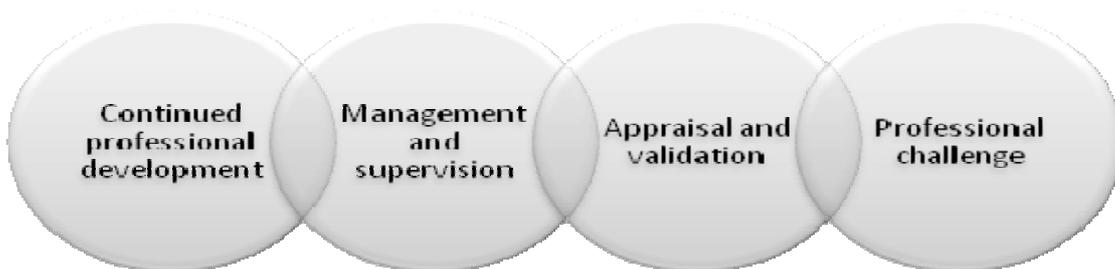
‘The openness of a culture- its ability to support the exchange of information at all levels, without fear and against authority gradients – is known to be associated with safety in high risk systems. So called ‘high reliability organisations’ have been found to exhibit at least five characteristics ...

1. A constant awareness to the possibility of hazard or harm, and a sensitivity to early signs of failure
2. The willingness and capacity to look beyond first impressions, labels and old beliefs
3. An ability to remain closely in touch with activities and facts on the ground in the daily operations of the organisation
4. Support for continual learning, growth and adaptation, even under stress, as facts and context change
5. Valuing relevant knowledge, skills and observations, even at the lowest levels of hierarchy’

A ‘Team Clinical Assessment Measure’ programme is available at www.nrls.npsa.nhs.uk/resources/?entryid45=59796

6.2.1 Prevention and Workforce

Staff development systems are important mechanisms to reinforce the attitudes and behaviours that prevent safeguarding concerns arising, helping staff to take responsibility for their own practice and to challenge others.



- **Managing Performance and Concerns.**

Prevention of harm and abuse also involves taking early action where there are concerns about a workers practice, supporting them to improve.

Where significant concerns about a worker arise, this requires decisive actions which may include disciplinary action; referral onto professional bodies; referral in line with the Safeguarding Vulnerable Groups Act; referral to the police.

The National Clinical Assessment Service provides guidance for managers and practitioners of Doctors and dentists, to understand, manage and prevent performance concerns.

<http://www.ncas.npsa.nhs.uk/>

- **Whistle blowing**

Inquiries into institutional abuse have repeatedly found that some staff had held serious concerns, but were too frightened or unsure of how to raise them. Workers such as students can bring fresh insights to established institutions but they can often feel too powerless or compromised by their position to challenge.

Whistle blowing policies are important to have in place but will only be effective in a culture that is open to scrutiny, where staff at all levels feel confident that they can voice their concerns without fear of victimisation.

Staff need to have clear lines to report concerns within their service, and if necessary, outside of their service e.g. to their professional regulator or the Care Quality Commission.

Healthcare professional bodies provide support to staff to ensure that they are able to raise or escalate concerns. The NMC (2010) have produced guidance¹⁸, setting out the steps for nurses and midwives.

Where healthcare professionals fail to observe the standards required of them, action may be taken against them by their regulatory body.

‘Speaking up for a healthy NHS’ 2010 was written by the independent whistle-blowing charity, Public Concern at Work (PCAW) and is designed to help employers toward best practice in devising, implementing and auditing their whistle blowing arrangements.

- **Safe Recruitment and Safeguarding Vulnerable Groups Act 2006**

Safe recruitment is about arrangements for all staff – directly employed staff, volunteers, sub contractors, agency staff and students.



18

NMC developing practical guidelines for professionals on raising and escalating concerns: <http://www.nmc-uk.org/aArticle.aspx?ArticleID=3733>

Employers have a duty to act in line with the Safeguarding Vulnerable Groups Act 2006. This relates to checks made at point of recruitment and to making a notification where a person has been removed from regulatory activity because they are believed to have caused harm (or pose a risk of harm) to children or vulnerable adults.

The 'NHS Employment Check Standards' provided by NHS Employers assists in safe recruitment.

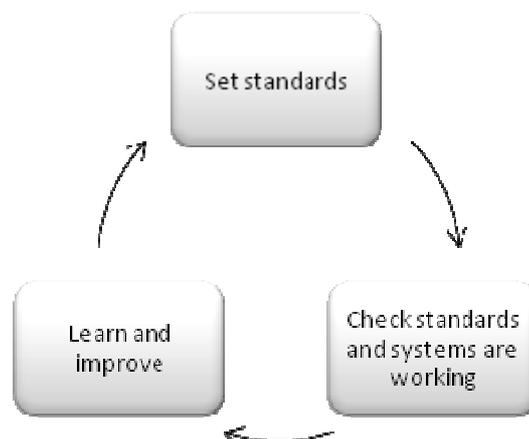
6.2.2 Standards for Care.

Standards are key to meeting the care of all patients but are particularly important to patients who may be at greatest risk of neglect, harm or abuse.

Standards ensure their individual support needs are met from point of first contact and throughout their care.

- Regulatory standards. The Care Quality Commission, Essential Standards of Quality and Safety are all fundamental to reducing the risk of neglect, harm and abuse.
- Clinical standards, such as the Essence of Care provide important benchmarks for basic elements of care
- Legislation such as the Equality Act 2010; Mental Capacity Act 2005 and Human Rights Act 1998 establish the statutory duties for services and provide important rights for all patients, carers and staff, including specific protections related to disability, age and mental impairment.
- Statutory guidance such as the Mental Capacity Act Code of Practice direct how the law should be applied

Setting standards and measuring how they are used in day to day care, allows services and practitioners to identify concerns about individual patients and trigger early warnings about poor care in services.



Practice Examples - Prevention

- An A&E system identifies that a patient is developing a pattern of repeat attendances and triggers a further assessment to determine if the person is in need of additional support.
- The admission assessment of a person with advanced dementia, flags the need for additional support in eating and drinking.
- An Acute Trust identifies a peak in numbers of patients with grade 1 & 2 pressure ulcers and uses root cause analysis to bring about improvement.
- A mental health independent provider receives a series of complaints from patients about staff attitudes on a secure ward and involves a advocacy service in the investigation
- A service specialising in care for people with autism notes an increase in the use of restriction and restraint and carries out a review
- A care home introduces dementia care mapping to understand and improve staff interactions with residents
- An ambulance service identifies particular problems arising from discharge during early evening and liaises with the discharge coordinator.

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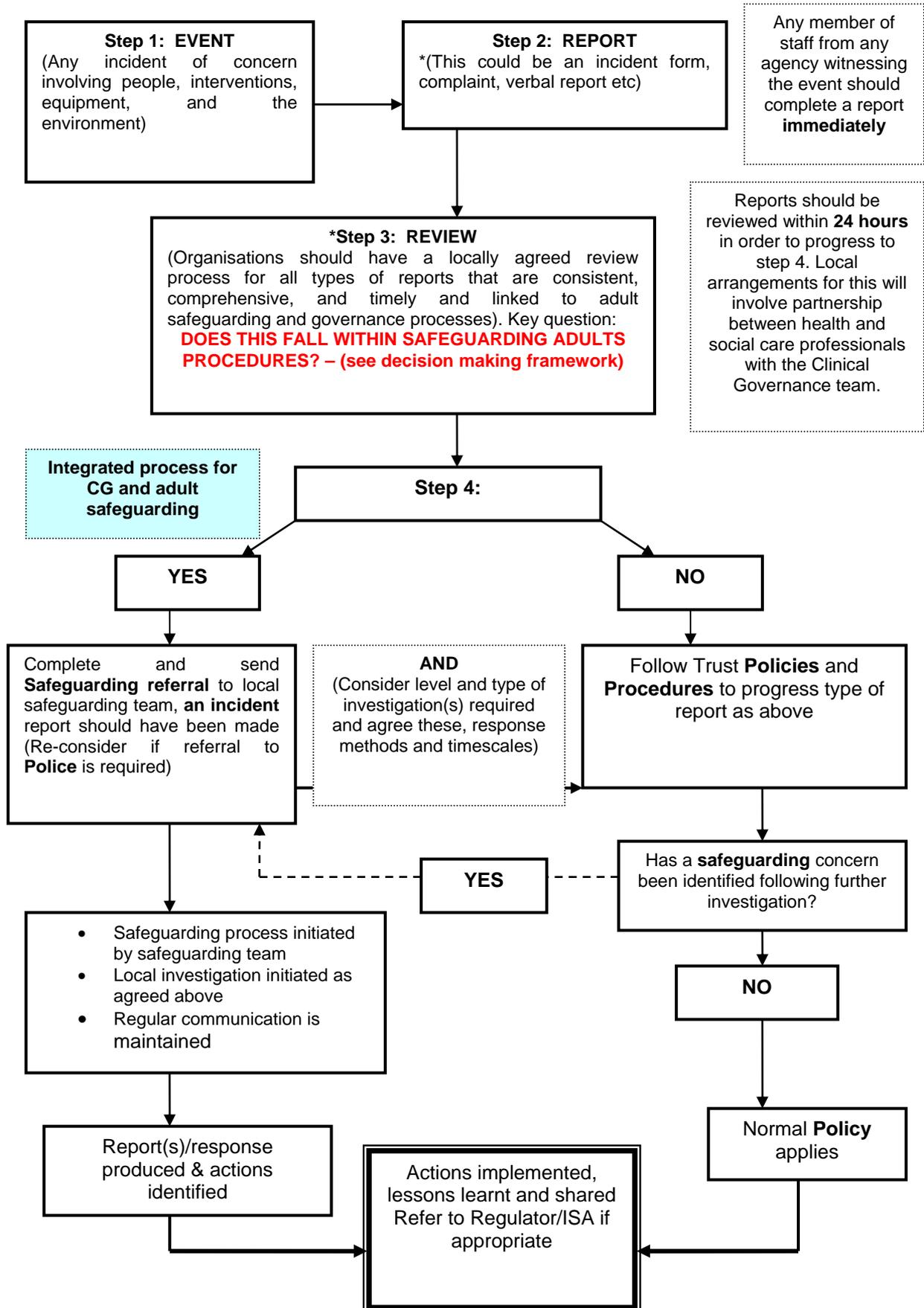
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Annex 1

Safeguarding adults and roles within the workforce.	
Role	Key Functions
Executive/ Senior Management Lead	<p>Leadership across the organisation</p> <p>Set strategic safeguarding objectives.</p> <p>Connect aligned strategic areas</p> <p>Accountability for the governance of safeguarding – to the service, partners and regulators</p> <p>Leadership for a partnership approach & within the Local Safeguarding Adults Board.</p>
Non executive and elected leads	<p>Champion & maintain focus on safeguarding</p> <p>Provide independent scrutiny</p> <p>Hold executive directors and Boards to account</p>
Operational lead	<p>Deliver strategic objectives & lead across the service</p> <p>Manage the safeguarding workforce</p> <p>Provide systems and structures to support safeguarding e.g. procedures, training</p> <p>Quality assure safeguarding adults practices</p> <p>Manage complex or high risk situations</p> <p>Work collaboratively with partners</p>
Safeguarding Specialists	<p>Clinical leadership & expert practice</p> <p>Lead improvements, innovations and best practice</p> <p>Develop and delivers training</p> <p>Provide supervision</p>
Decision maker e.g. senior clinician; line manager; team leader	<p>Make decisions about referrals to the Local Safeguarding Adults service</p> <p>Manage any immediate protection issues</p> <p>Coordinate referral and safe transfer of responsibilities.</p> <p>Coordinate any alternative action plan</p>
Roles in Multi Agency Procedures	<p>Potentially including:</p> <p>Lead/ coordinate</p> <p>Investigate standards of health care delivered by services or individuals</p> <p>Contribute specialist expertise to an investigation</p> <p>Assess the patient's needs</p> <p>Assess the needs of those causing harm</p> <p>Coordinate or contribute to the protection plan and recovery of the patient or those causing harm</p>
Wider workforce	<p>All staff are responsible in identifying and responding to concerns about quality and adult safeguarding</p>

Learning and Development – Prompts to evaluate provision
<p>Planning</p> <p>What should the whole workforce know about safeguarding? Is safeguarding part of pre- registration programmes and post registration? Is there a workforce strategy that addresses the different roles and responsibilities required for safeguarding? Is the workforce strategy linked to a learning and development plan? Is the learning and development plan resourced? What is the frequency and content of refresher training? Does the learning and development plan take forward the services' and the local Safeguarding Adults Board's strategy?</p>
<p>Content</p> <p>Does the training contain competencies matched to the roles and responsibilities? How do training materials reflect developments and learning from lessons – internal, local and national? Is learning and development informed by the experiences of patients? Does learning reflect the multi agency approach e.g. opportunity for multi agency training? Are there opportunities for specialist training – e.g. investigations of healthcare? How does the content promote a Human Rights and Equality based approach?</p>
<p>Outcomes</p> <p>How is training validated and evaluated? How are learning and development outcomes reported – to the service; to Local Safeguarding Adults Board Is training making a difference? How is this tested?</p>

Annex 2 SAFEGUARDING ADULTS & CLINICAL GOVERNANCE FLOWCHART



Flow chart guidance notes.

Step 1: Event or incident

1. An incident of concern is reported. (This could include an oral or written complaint or concern raised by anyone with regard to a person, place or act, or any type of incident). This report should be completed immediately after the event has occurred. It can also be made directly to the commissioner and regulator.
2. Confirm any immediate safety issues have been addressed. Consider whether a crime has been committed.
3. Consider the person at the centre of the event (e.g. a member of staff or a patient, or both) and the information and support they may require during and after the incident.

Step 2: Report

1. The person who has identified the concern, reports this, in line with local organisational procedures and regulatory requirements e.g. completion of an incident/serious incident form
2. Details about any immediate or on-going care for the person are recorded within the patient's notes/HR files as appropriate.

Step 3: Review

- i). The incident form/complaint is reviewed within 24 hours to identify if harm has occurred that requires a safeguarding adults response. (This will be in addition to any action subsequently to be taken under the multi agency procedures and NHS Complaints (England) Regulations 2009)

**Consider: Is this a safeguarding concern that falls within
safeguarding adults procedures?**

- ii) Services should have robust local processes in place to ensure that this review is comprehensive, timely and effective. This should be linked into existing governance processes for incident reporting/complaints, etc. so that review forms part of this process. The process should be in line with local multi-agency safeguarding adults procedures and protocols.

A suggested framework for decision making is provided below.

- iii). Ensure that appropriate notifications are made to CQC (via patient safety reporting systems for NHS services). Communicate with commissioners, regulators and governing bodies according to national and local guidelines.

Step 4: YES or NO

1. A 'yes' or 'no' route is then selected.
2. In the event that there is a safeguarding concern, complete a referral in line with local procedures and send to the safeguarding team. (An incident form should still have been completed in addition)

3. Normal trust policies and procedures for follow on actions still apply and should be carried out in partnership with the safeguarding process.

If there are no apparent safeguarding concerns, normal procedures for investigation etc. should apply. However, if through the investigation process a safeguarding concern should emerge, an alert should be raised immediately and progressed as above.

Notes: Direct Referral

In the unlikely event, that a safeguarding concern is not progressing satisfactorily within organisations systems, staff involved in raising the incident or alert, may send/discuss the concern directly with the local safeguarding adults service (see local Adult Safeguarding policies and procedures) and directly with their commissioners.

Decision Making Framework

The framework provides guidance to weigh up whether a complaint or incident should be referred through safeguarding adults procedures. Many of the factors are likely to be on a continuum of concern and no singular decision will determine that a referral should *not* be made. The framework is an aide to weigh up *all* the factors in the round to help reach a considered and defensible decision.

This must be a 'broad brush' assessment that should not try to replace the more detailed assessment that would happen within the local safeguarding adult service. Where there is any doubt, the decision maker should consult with the local safeguarding adults service.

Remember:

- A safeguarding adults referral is about fuller, consideration with multi agency partners on the best way forward – referral does not necessarily lead to an investigation under formal safeguarding adults procedures.
- A safeguarding adults referral is about finding the best way to support the patient – it accesses wider multi agency information, perspectives, skills and resources
- A safeguarding adults referral is about accountability, openness and transparency – it is about learning and improving patient care.
- A safeguarding adults referral is NOT about pre determining that neglect or abuse has occurred. It is the start of seeking more information, finding out if something went wrong and then putting it right.
- A safeguarding adults referral is NOT about setting up long and complicated investigations by other agencies. The response must be proportionate and in many cases the service may lead the response.

Clinical Governance and Safeguarding Adults Decision Making Framework	
Factors to consider when deciding whether an incident or event should or should not be referred through the multi-agency Safeguarding Adults procedures	Factors considered– Note – no single factor will determine that a referral should <i>not</i> be made.
The Patient(s)	
Did the person experience harm?	
Are others at risk of harm?	
Was the person’s vulnerability likely to be relevant or was it coincidental to the concern?	
Was the impact of the incident likely to be greater because of the person’s vulnerability?	
What is the person’s capacity, support needs and ability to advocate for themselves?	
What are the patient’s wishes about how the concern should be dealt with? Is there a duty to act?	
Is cooperation needed from other agencies to keep the person safe?	
Alleged Incident	
What was the degree or nature of harm?	
May other agencies have relevant information that could affect this judgement?	
Is there divergence from acceptable standards without good rationale and did this lead to harm?	
Where this is a low level concern, is the cumulative affect leading to harm?	
What is the likelihood of recurrence?	
Environment – the worker and the service	
Are there themes and trends – is this a recurring pattern for the worker and/or the service?	
Is there suspicion or evidence of negligence, incompetence or recklessness?	
Is there suspicion or evidence of, lack of integrity or malicious intent?	
Is there an allegation of misconduct by a member of staff to a ‘vulnerable adult’? If so refer to Local Safeguarding Adults Service	
Could this be a criminal offence? If so refer to police and Local Safeguarding Adults Service	
Outcome of decision	
Decisions to refer/ not refer through local safeguarding adults procedures and reasons	
What other processes/systems are being used to address the problem? Do they adequately address the incident or would something be missed? Reference table 1	

Table 1 considers the various reporting routes for managing incidents and complaints and the added value of a multi-agency approach.

Table 1 Incident Governance Processes and Potential Outcomes		Reporting Outcomes								
		Meets Patient Safety	Internal governance	External scrutiny	Single Agency Investigation	Multi agency investigation	Single Agency support to patient	Multi agency support to patient and family	Single agency learning	Multi agency learning
Reporting Processes	Clinical incident	☑	☑	X	☑	X	☑	X	☑	X
	Serious incident	☑	☑	☑	Note 1	☑	☑	X	☑	☑
	PALS	☑	☑	X	☑	X	☑	X	☑	X
	Complaint	☑	☑	X	☑	X	☑	X	☑	X
	Disciplinary; capability measures	☑	☑	Note 2	☑	X	☑	X	☑	X
	Safeguarding referral	☑	Note 3	☑	☑	☑	☑	☑	☑	☑
<p>Note 1 – May be investigated externally dependent upon the grading of the serious incident Note 2 – May be referred to professional bodies and as required by SVG Act provisions Note 3 – Subject to integrating safeguarding adults with organisational governance frameworks</p>										

Annex 3

Internal Safeguarding Adults Procedures Checklist

Internal procedures provide the mechanism for a service to manage safeguarding adults concerns. The procedures need to be aligned with multi agency procedures to ensure a consistent and coordinated approach.

The Safeguarding Adults Internal Procedure Includes	√
Identify and Make Decisions	
The mechanism for all staff to raise a safeguarding concern	
Whistle blowing procedures	
Identifying the patient’s views and desired outcomes	
Consideration of the patient’s mental capacity in relation to the range of decisions required to safeguard their well being. – assessment and recording requirements	
Best interest decision making where the patient lacks mental capacity for the relevant decision	
How human rights and equality is considered in making decisions.	
Consideration of any overriding duties to act.	
The immediate responses required to protect the patient or other adults or children.	
Guidance on contacting police where required	
Which staff can make decisions about whether the concern falls within adult protection procedures and coordinates the referral	
Record of the decision made relating to the concern and reasons	
Record of alternative care plan and responsibilities	
Actions the staff member can take if they are concerned about the decision made	
Actions to take where the organisation disagrees with the referral decision made by the Local Safeguarding Adults service	
Multi agency safeguarding	
Roles and responsibilities in the safeguarding strategy	
Roles and responsibilities of investigators and assessors	
Roles and responsibilities within the protection plan	
Roles and responsibilities within review and ending procedures	
Mechanism to track progress of a concern through procedures	
Patient involvement and support provided to the patient at each step of the procedures	
Outcomes and learning	
Evaluating patients outcomes	
Evaluating other outcomes – e.g. changes to the service	
Identifying and reporting lessons for the organisations	
Developing and implementing action plans arising from learning	
Roles and responsibilities in serious case reviews	
Mechanism to collate and report outcomes and learning	

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Recording and Reporting	
Data sets required e.g. source of concern; setting; data related to protected characteristics under Equality Act; primary need; timeframes; outcomes	
Reporting procedures for safeguarding adults concerns and referrals within clinical incident/serious incident systems	
Recording in patient records	
Reporting to senior managers/Board	
Reporting to commissioners	
Reporting to Care Quality Commission	
Reporting to professional regulators	
Reporting in line with Safeguarding Vulnerable Groups Act requirements	
General	
Information sharing guidance	
How internal procedures map to multi agency procedures	
Supervision and support arrangements	
Cross reference to other relevant policies, multi disciplinary procedures	
How the procedure promotes human rights and equality	
Lines of accountability	
Cross references to other key procedures e.g. disciplinary procedures; serious incidents; capacity and consent	

Annex 4

Health Focused investigations of Neglect

Introduction

Multi agency safeguarding involves coordinating an investigation, assessment and protection plan.



Health staff contribute expertise across all these key stages. This appendix provides a quick reference guide to investigation of neglect in care settings.¹⁹

Step 1 – Remember the safeguarding principles!

- Empowerment means involving the person throughout the process, working toward the outcomes they want.
- Proportionality and least intrusive responses are key aspects of risk assessment and management.
- Accountability and transparency involves sound evidenced based decisions that are open to scrutiny.

¹⁹ For further information see Phair L & Heath H; Neglect of older people in formal care settings part one; new perspectives on definition and the nursing contribution to multi-agency safeguarding work; The Journal of Adult Protection Volume 12 Issue 3, 5-13; 2010

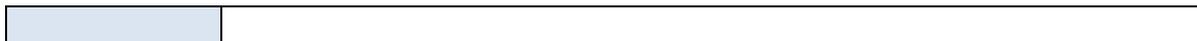
Phair L, Heath H; Neglect of older people in formal care settings part two: new perspectives on definition and the nursing contribution to multi-agency safeguarding work The Journal of Adult Protection Volume 12 Issue 4, 6-15; 2010

Step 2 – The strategy

The multi agency strategy meeting/discussion is a key step to coordinate and define the investigation

<p>What?</p>	<p>Define the remit of the investigation What time span is being covered? What is the scope – physical examination; interviews, record review? Single or multiple concerns What is the focus e.g Whether neglect has occurred Impact on the person Cause of harm Mitigating factors Securing evidence Professional, regulatory or contractual breaches Assessment of risks Are recommendations actions required?</p>
<p>Who?</p>	<p>Knowledge expertise and competence for the remit Any specialist opinion required Independence, objectivity and freedom from coercion Any professional or personal conflict of interest</p>
<p>When?</p>	<p>How urgent – what risks? Balance urgency with need for preparation and involvement Timeframes for reporting</p>
<p>How?</p>	<p>Coordinate with any other parallel investigations - avoid multiple interviews Plan how to achieve best evidence²⁰ Pre investigation preparation Who needs to be informed? Capacity and consent considerations Best means for involvement – communication aids; advocacy – IMCA; interpreter? Cultural considerations? Information to inform the investigation Whether, in exceptional circumstances, the investigation should be unannounced</p>

²⁰ Achieving best evidence in criminal proceeding; Guidance on interviewing victims and witnesses and using special measures; Criminal Justice System 2000



Step 3 – Carrying out the investigation

Local procedures may guide the investigation. The National Patient Safety Agency have also developed tools in investigations www.nrls.npsa.nhs.uk/resources .

Finding Information
Care records- risk assessments; medication charts etc Medical records Interview statements- staff, patients, families Management records – accident reports; staff rotas etc Menus Records from visiting professionals; reports, complaints from families Observation of environment e.g. hygiene, odours, atmosphere CQC inspection reports; commissioning data
Supporting tests and evidence
Blood urea, electrolytes, urine analysis to measure hydration Metabolic screening –detect nutritional or endocrine abnormalities Blood count and coagulation studies to detect easy bruising Drug levels and toxicology screen to detect substance misuse and over or under medication Radiology screening to detect old fractures Cultures to detect sexual abuse
Interviewing
Remember the principles of person led decisions, consent and involvement Is advocacy required – should this be an IMCA? How can the interview be managed in a sensitive and culturally competent way? Achieving good evidence – should others be present?
Recording
Record and reference information Will sketches, photos and copies help recording? Consider information governance procedures

Step 4 – Has neglect occurred?

Investigation is based on balancing probabilities of neglect occurring
Consider 4 determinants²¹

21 Heath H & Phair L; The concept of frailty and its significance in the consequences of care or neglect for older people; an analysis
International Journal of Older People Nursing 4, 120-131; 2009



The findings should be balanced, objective and accurate and where possible referenced.

Step 5 – Mitigation

Where neglect is identified, mitigating factors do not deny the findings but may affect actions arising.



Step 6 - Reporting

Reporting

- Report on areas within your expertise and within the scope of the investigation
- State facts & evidence – be clear where opinion is used
- Reference the source of information and any guidance or standards used
- Use a clear structure leading to a logical conclusion
- Use understandable language – avoid jargon and provide any technical explanation

Step 7 – Outcomes

The report will be used, alongside any other investigations, to determine what protection plans need to be put in place and any actions that are required of the service.

Outcomes

- Be clear about any follow up actions
- Who needs to be informed?
- Who is responsible?
- Responsibilities for developing, implementing and assuring action plans
- Are any notifications required e.g. CQC; professional regulators; notification under Safeguarding Vulnerable Groups Act?
- Who is responsible for notifying?

Practice Example 1

A man is admitted to hospital from a care home. A&E staff raise a safeguarding alert because he was drowsy, dehydrated, had five pressure ulcers on his sacrum and shoulders and a body mass index of 17.

The investigation found that:

- The home was working closely with the primary care team
- A profiling bed, and a high specification mattress were in place.
- The man had been having intermittent sub-cutaneous fluids and nutritional supplements
- Cancer with metastases had only recently been diagnosed
- He had a history of diabetes and dementia
- The home had increased staff levels.
- The Gold standards Framework for end of life care was in place and community nurses called every day but his condition continued to deteriorate
- Records were all in order including fluid and repositioning charts.
- The man and his family were fully involved in his care
- The home accessed the right services when he had a seizure.
-

Outcome of the safeguarding investigation:

Allegation of neglect unsubstantiated

Abridged from Phair L, Heath H; Neglect of older people in formal care settings part two: new perspectives on definition and the nursing contribution to multi-agency safeguarding work The Journal of Adult Protection Volume 12 Issue 4, 6-15; 2010

Practice Example 2

A man was admitted to hospital with a fractured neck of femur. He lived in residential care and had vascular dementia. He was able to communicate and was almost self caring and was continent.

- During his 4 week admission, he deteriorated significantly – he was doubly incontinent; lost 14kg; he became agitated and confused, at times tried to hit staff. The family complained but were informed that the deterioration was not unusual due to his health needs and the weight loss was because he chose not to eat. The family made a referral to Local Safeguarding Adults services, believing the man had been neglected.
- The investigation found:
- The care plans did not take any account of his dementia e.g. supporting him to eat
- There was lack of essential assessments and documents e.g. no fluid charts; no continence assessments; no record of weight checks
- No blood tests were carried when he became involved
- No involvement of necessary professionals e.g. his community mental health nurse
- Blood tests taken by the GP the day after discharge indicated severe dehydration

Outcome of the safeguarding investigation:

Allegation of neglect was substantiated

Abridged from Phair L, Heath H; Neglect of older people in formal care settings part two: new perspectives on definition and the nursing contribution to multi-agency safeguarding work The Journal of Adult Protection Volume 12 Issue 4, 6-15; 2010

Annex 5

Acknowledgements

The Department of Health would like to thank the following people who contributed to the development of the safeguarding adults materials for health services.

Jules Acton	National Voices
Geoff Baines	NHS South West
Tim Bishop	NHS Peterborough
Liz Biebuyck	Independent Consultant
Janet Boorman	East London Foundation Trust
Lucy Bonnerjea	Department of Health
John Canning	British Medical Association
Nicola Clark	NHS London
Dawn Clarke	NHS North West
Rebekah Cresswell	NHS North West
Harry Cronin	NHS North East
Paul Coleing	Care Quality Commissioner
Nyla Cooper	NHS Employers
Keren Corbett	NHS West Midlands
Claire Crawley	Department of Health
Jan Crozier	NHS South West Essex
Jean Daintith	Royal Borough of Kensington & Chelsea
Maureen Davies	NHS London
Alison Dittmer	Health Professionals Council
Vicki Dixon	NHS South East Coast
Sherree Fagge	Brighton & Sussex University Hospitals NHS Trust
Gary Fitzgerald	Action on Elder Abuse
Penny Furness-Smith	Association Directors Adult Social Services
Will Frost	British Medical Association
Maggie Gallagher	NHS West Midlands
Paul Gantley	Department of Health
Jane Garner	Royal College Psychiatry
Robert Goodman	NHS Direct
Sandra Gray	NHS West Midlands
Lene Gurney	Independent Healthcare Advisory Services
Nicky Hayes	King's College Hospital
Caroline Heason	NHS South Central
Amanda Howe	Royal College GPs
Dr David Hunt	Western Sussex Hospital
Munyaradzi Hute	NHS London
Ruth Ingram	Calderdale County Council

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Mala Karasu	Guys and St Thomas' NHS Foundation Trust
Louise Lawton	Care Quality Commission
Stephen Leyshon	National Patient Safety Agency
John Lewis	DH East of England
Carol McKeough	Kent County Council
Helena McKeown	British Medical Association
Hampshire Health Consortium	
Sylvia Manson	Department of Health; NHS Northamptonshire
Anna Morgan	Department of Health
Veronica Monks	Department of Health
Val Murray	NHS North East
Ann Norman	Royal College Nursing
Matt O'Conner	NHS Bradford & Airedale
Lynne Phair	Department of Health
Leo Quigley	Department of Health
Suzanne Rankin	NHS South Central
Geraldine Sands	NHS Yorkshire & Humber
Deborah Sturdy	Department of Health
Patricia Suarez	NHS Confederation
Lyn Sugg	London Ambulance Service
Ruth Symons	NHS Litigation Authority
Beverley Tabernacle	Salford Royal NHS Foundation Trust
Elaine Taylor	South Essex Trust
Judith Thorley	NHS East Midlands
Martine Tune	Nursing and Midwifery Council
Alison Wall	Nursing and Midwifery Council
Jo Webber	NHS Confederation
Judy Weleminsky	Care Providers Forum